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ABSTRACT

This report, in two volumes, contains recommendations and supporting documentation for restructuring mental health services to Texas' children with an emphasis on the cost effectiveness of developing accountable school and community based services, family centered prevention services, and early intervention services. Major mental health issues for Texas schools, families, and children include: the mental health needs of children are not being met; currently most of the mental health funding is for the most restrictive and most expensive service model (residential placement) which serves only a few children in need; and the least amount of mental health funding is for the most cost-efficient and effective delivery model--a preventative, family-oriented, community-based consortium of services. Among eight major recommendations are: (1) focusing funding to develop effective school and community based services; (2) development of a statewide Comprehensive Community-Based Children's Service Plan; and (3) systematic evaluation of all residential placements of children with emotional problems. Additional sections of Volume I provide background information, the four legislative mandates to the task force, and various funding strategies. An appendix gives several definitions of emotional disturbance and 29 footnotes are listed. Volume II provides supporting documentation in 12 papers and 6 appendixes. Papers cover an inpatient facility study, a residential facility study, a report on student outcomes in residential placements, a continuum of services, a survey of community mental health services, family treatment models, a parent survey, and preventive programs. A bibliography of 37 references in addition to individual paper references are included in Volume II. (DB)

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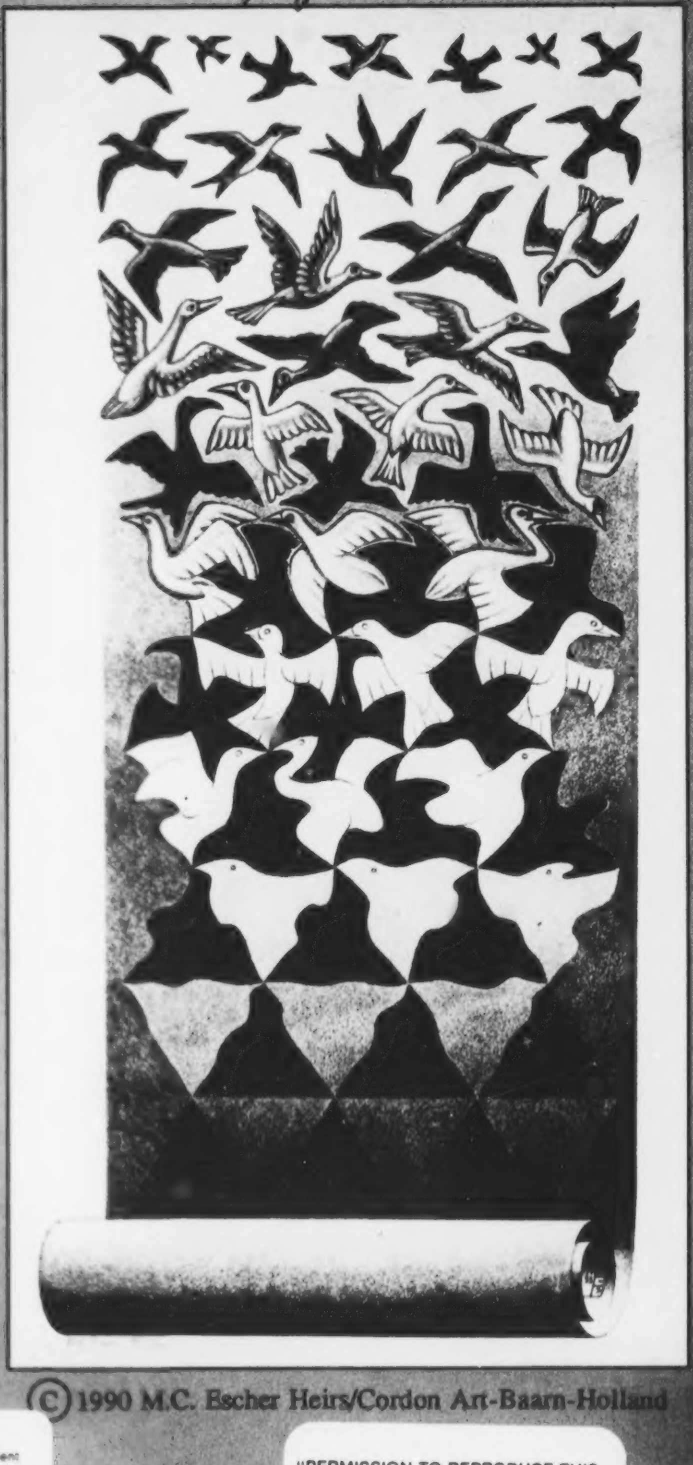
1 of 2

Education and Mental Health:

Profitable Conjunction

Volume I



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EDUCATION AND MENTAL HEALTH: PROFITABLE CONJUNCTION
VOLUME I

Report of the Joint Texas Education Agency/
Texas Department of Mental Health and Mental
Retardation Task Force on Emotional Disturbance

Submitted to the Governor; Lieutenant Governor,
And the Seventy-Second Texas Legislature

1989-1990

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Texas Education Agency
1701 North Congress Avenue
Austin, Texas 78701-1494

State Board Of Education
1701 North Congress Avenue
Austin, Texas 78701-1494
(512) 463-9007

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San Antonio, District 3

W.N. Kirby, Ph.D.
Commissioner of Education
(512) 463-8985

January 1991

The Honorable Ann W. Richards, Governor of Texas
The Honorable Bob Bullock, Lieutenant Governor of Texas
The Honorable Gibson D. Lewis, Speaker of the House
Members of the 72nd Legislature

Section 1.11 of the Texas Education Code required the Texas Education Agency to continue the Joint Texas Education Agency/Texas Department of Mental Health and Mental Retardation Task Force on Emotional Disturbance. The task force was mandated to conduct a study to evaluate and make recommendations concerning residential costs, the creations of community-based services, family involvement, and early intervention and prevention strategies specific to children and youth with emotional disturbance.

This report contains recommendations for restructuring mental health services to children and youth. The Joint Task Force on Emotional Disturbance believes that the restructuring as described in this report will result in more cost-effective services to children and youth.

I hope you will find this information useful as you continue to address mental health issues pertaining to children and youth with emotional disturbance.

Respectfully submitted,

Carolyn Crawford

Carolyn Honea Crawford, Chairman
State Board of Education

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MEMBERS OF THE JOINT TEXAS EDUCATION AGENCY/TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION TASK FORCE ON EMOTIONAL DISTURBANCE

Jo Ann Mitchell Burns, Ed.D.
Pan American University

Clint Capers, M.Ed.
Waco Center for Youth

Cheri Crane, M.Ed.
Crane/Reynolds, Inc.

Grace England, Ph.D.
Klein Independent School District

Sara Gonzales
Texas Alliance for the Mentally Ill

Ruth Haak, Ph.D.
Balcones Coop, Austin

Regenia Hicks, Ph.D.
Texas Department of Mental Health and Mental Retardation

Karen Jackson, Ph.D.
Texas Woman's University

Scott Keir, Ph.D.
Hogg Foundation for Mental Health

Betty Phillips, Ph.D.
Austin Independent School District

Ruth Turner, Ed.D.
Dallas Independent School District

Beverly Sutton, M.D.
Austin State Hospital

Jo Webber, Ph.D.
Southwest Texas State University

Kimberly Hoagwood, Ph.D.
Chair, Joint Task Force
Texas Education Agency

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EXECUTIVE SUMMARY

The Texas Education Agency was mandated by the 71st Texas Legislature in Senate Bill 417 to continue the Joint Texas Education Agency/Texas Department of Mental Health and Mental Retardation Task Force on Emotional Disturbance (hereafter called the Joint Task Force). The Joint Task Force was asked to conduct a study to evaluate the appropriateness and cost-effectiveness of residential placements, the creation of community-based services, the creation of a family-centered system of services,* and early intervention and prevention strategies for children and youth with emotional disturbance.**

This report contains recommendations for restructuring mental health services to Texas' children--restructuring that would result in more cost-effective services. Major findings include the following.

- Texas spends $60 million dollars of public money every year for residential (i.e., out-of-home) placements of children with severe emotional disturbance. This amount represents two-thirds of the total public expenditures for Texas children with emotional disturbance. Most of the public funds for children with emotional disturbance are spent to place a few of these children in the most restrictive settings.

- The $60 million of public money spent on residential placements for children with emotional disturbance amounts to more than $5 million every month. The U.S. Government Select Committee on Children, Youth, and Families predicts an increase of 17% per year in the number of children with serious emotional or behavioral disorders who will be placed residentially. That rate of increase would cost the state an additional $18 million in 1991 and $21 million in 1992 for residential placements of these children. To make matters worse, these placements are almost always outside the child's community.

- Outcome data from the Joint Task Force study of all residential placements used by school districts indicates that only 25% of the children placed are successfully discharged back into their community. Contrary to expectations, increased length of stay does not necessarily predict successful outcomes. Furthermore, more expensive services did not guarantee successful discharge. According to respondents, longer placements were often linked to the lack of community-based services.

- The Joint Task Force study indicates that the development of accountable community-based services*** could reduce residential placements. The Joint Task Force estimates that 50% or more of children in residential placements could be served in the community if more accountable school- and community-based services were available. Furthermore, the costs per child for implementing these services are estimated to be over 80% lower than the cost for residential placement. Models of community-based services that involve local interagency planning, such as the Texas Children's Mental Health Plan, need to be implemented immediately to offset the projected increases of children in residential placements.

Developing carefully managed and accountable community-based services takes thorough planning at the state and local level. Texas is currently 49th in the nation in funding for mental health services; new funding will be needed to implement the recommendations of this report.

The effect of these new funds, however, will be to restructure the current system of mental health service delivery and move to a more cost-effective system of care for children that will save taxpayers money by reducing expensive and often ineffective out-of-home placements. A shift in funding priorities towards community-based services for children and towards family-centered prevention and early intervention services is the underpinning of the recommendations that are proposed.

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* The term "family-centered services" describes the task force recommendation that services should be provided within the child's home and community whenever possible. It refers to services both for families and caregivers.

** Children and youth with emotional or behavioral problems in need of mental health services are defined as all children and adolescents (referred to in the remainder of the report as "children") currently identified by any agency as needing mental health services and children who are at risk for being identified.

*** In this report, the term "community-based services" includes school, office, and home-based services to children and their families. For a full explanation of these types of services, see Volume II of this report.

MAJOR MENTAL HEALTH ISSUES FOR TEXAS SCHOOLS, FAMILIES, AND CHILDREN

1. **Texas is not serving the mental health needs of its children.**

   - 600,000 Texas children have mental health needs; 100,000 need public mental health services, but only 22,000 received services in 1988.[1]
     - From 1983-86, there was a 50% increase in juvenile arrests.[2]
     - Almost one-half of Texas school children use illicit drugs at least annually.[3]
     - Texas has a higher than national average youth suicide rate.[4]
     - Texas leads the nation in pregnancies for girls under the age of 14.[5]

   - One-third of the 35 mental health centers in Texas do not provide services to children.[6]

   - Texas ranks 49th in the nation in funding for mental health services; only one state spends less than Texas.[7]

   - Current funding requests for core mental health services to children for 1990-91 will serve only 10% of the children with serious emotional disturbance who need help.[8]

   - Texas ranks 42nd out of 50 states in the percentage of high school graduates. Of the identified students with serious emotional disturbance, there was a 44% drop-out rate in 1986-87.[9]

2. **Currently, Texas spends most of its limited mental health funding on the most restrictive, most expensive service model, reaching only a small percentage of children in need.**

   - For 1989, Texas spent $92,624,094 on all mental health services to children; two-thirds of this amount was spent on residential placement.[10]

   - Texas spends $60 million of public money every year for residential placement of approximately 3,545 children with severe emotional problems.[11]

   - For one three-year period, two-thirds of the students placed by school districts in residential facilities were either not in school, not making progress, or could not be found.[12]

   - It is estimated that 50% of the students placed residentially could be served more cost-effectively in their community.[13]

   - Little or no efficacy research has been conducted on residential treatment of children, although traditionally it has been the treatment option of choice.[14]

3. **Currently, Texas spends the least amount of its limited mental health funding on the more cost-efficient and most effective delivery model: a preventive, family-oriented, community-based continuum of services.**

. Outpatient counseling is not available for 49% of the children referred to community mental health centers in Texas.[15]

. Of the Texas community mental health centers surveyed, 34% did not indicate that family therapy services were available.[16]

. Of the Texas community mental health centers surveyed, 73% did not indicate that case management services for children were available.[17]

. Most (94%) of the Texas community mental health centers do not offer day treatment programs for children.[18]

. Nearly one-half of Texas special education directors surveyed reported that no community-based networks of outpatient services existed for their students.[19]

. Despite a national average of 3-5% of all school-age children identified as having serious emotional problems, one-third of Texas school districts did not identify a single student as seriously emotionally disturbed in 1986.[20]

4. **What does this mean for the people of Texas?**

. Without a strong preventive model, Texas citizens will continue to pay more and more for prisons, adult mental health services, welfare programs, and institutional placements.

. It is possible to significantly reduce these costs by:

.. offering a proactive, family-based system of mental health care;
.. identifying and treating young children who are at risk; and
.. treating children with manifested antecedents to emotional disturbance (i.e., drug/alcohol abuse, delinquency, school failure, child abuse, school dropouts) in the schools and/or the community.[21]

. A continuum of community-based mental health services for children and their families provides an effective alternative to the current nonfunctional system. Research, nationally, found that:

.. Of children in day treatment programs, 80% improved on clinical measures and 65-70% were reintegrated into regular school programs.[22]

.. Of the children treated in therapeutic foster care, 82% were successfully discharged to less restrictive programs, thereby costing half as much as residential placement.[23]

.. Intensive home-based services can lower the probability of residential placement for at-risk children by 50%.[24]

> *"I urge you to consider ways to help children before they and their families get into a crisis situation. We privately tried to care for our son's problems from September '89 through February '90, and as a result, are over $80,000 in debt. Our insurance has been exhausted and our problems have not been resolved."*
>
> Parent of 13-year-old boy with
> serious emotional disturbance

MAJOR RECOMMENDATIONS FOR RESTRUCTURING MENTAL HEALTH SERVICES TO CHILDREN

1. **The Joint Task Force recommends that focused funding be appropriated to develop effective school- and community-based services for children with serious emotional disturbance.**

Rationale: Sixty-million dollars is spent annually on the most expensive and restrictive services for a small number of children. Validated models of community-based care systems have been shown to be more cost-effective and to serve significantly more children and their families or caregivers. As Texas is currently underfunding children's mental health services, additional appropriations will be necessary to create accountable community-based systems of care. A large percentage of the funds should be allocated to provide direct service, rather than to meet agency administrative costs. An example of this type of allocation was the Texas Department of Mental Health and Mental Retardation $2 million appropriation in 1989 for children's mental health services.

The following initiatives, if funded, will create alternative systems of care:

- the Texas Children's Mental Health Plan ($43,075,854);
- managing and evaluating the Texas Children's Mental Health Plan ($100,000); and
- developing and implementing the Interagency Training Model planned by the Commission on Children, Youth, and Families ($75,000).

2. **The Joint Task Force recommends that management and evaluation of the Texas Children's Mental Health Plan be assured through development of a statewide Comprehensive Community-Based Children's Service Plan.**

Rationale: The Joint Task Force recognizes that layering effective services on top of an inefficient system will not work. To implement effective, statewide community-based services for children with severe emotional problems and their families, a long-range plan, using validated models, needs to be developed by the agencies represented in the Texas Children's Mental Health Plan. This plan should build upon and expand the Texas Children's Mental Health Plan, should be facilitated by the Mental Health Association of Texas, and should be coordinated with the Texas Department of Mental Health and Mental Retardation service system plan for children and adolescents. (See Volume II.)

To be effective, the Comprehensive Community-Based Children's Service Plan must itemize essential service components, determine both the size and cost of these components, and fund local demonstration sites for statewide implementation. Components of the service plan that need cost analysis must include:

- education;
- the full range of mental health services;
- substance abuse prevention;
- social services and child protective services;
- juvenile justice;
- physical health;
- vocational services; and
- recreational services.

The Comprehensive Community-Based Children's Service Plan should also ensure that the implementation of these services is carefully coordinated at the local level. A full implementation of the core services for children developed by the Texas Department of Mental Health and Mental Retardation should be a requisite component of the plan.

3. **The Joint Task Force recommends that schools become the focus for providing physical and mental health services in the community.**

Rationale: Schools can accomplish their educational mission only if they attend to the emotional, social, and physical needs of their students. The mental health and educational needs of children are inextricably intertwined. The school campus should become the hub of the community, so that health services, including early identification, referral, and student assistance programs can be provided immediately to children and their families.

Specific recommendations include the following.

- Community agencies should be encouraged to provide mental health services in schools.

- Schools should increase their service capacity and establish collaborative relationships between internal service programs and external agencies to provide comprehensive health services on their campus.

- The role of school support personnel needs to be restructured so that they can provide much needed mental health services along with other mental health professionals in the schools. School counselors, school psychologists, social workers, and nurses should be enabled to do what they do best: intervene and consult with teachers, children, and their families or caregivers.

4. **To foster more responsible use of public dollars, the Joint Task Force recommends that all agencies currently spending public dollars on residential placements of children with emotional problems systematically evaluate the outcomes of these children to ensure that the most appropriate and effective programs are funded.**

Rationale: One of the problems that makes serving children with emotional disturbance difficult is the dearth of reliable data. Making research and evaluation of programs for children with emotional disturbance a priority will identify those programs whose success suggests replication. Knowledge of the strengths and weaknesses of current programs can be used to assure high quality and cost-effective services to children in our state. While direct service needs for children with emotional disturbance are great, the support of decisionmakers will be elicited by supplying them with essential information with which to make funding choices. Continued research and systematic evaluation is the best way to ensure that the most appropriate and cost-effective programs are funded with public dollars.

5. **The Joint Task Force recommends that extensive training be organized immediately for all agency personnel working with children with emotional disturbance.**

Rationale: The school and mental health systems are currently burdened by the need to serve increasing numbers of children and families whose problems are complex and for which there are no simple solutions. There are many innovative developments in identifying and serving children with emotional problems and their families through community-based, school, and home-linked services. However, there remains much inconsistency in even basic knowledge about identifying children who are at risk for developing severe emotional problems. Training is essential to ensure greater consistency.

Specific recommendations include the following.

- The Joint Task Force supports the Interagency Training Group, organized by the Texas Department of Mental Health and Mental Retardation, and recommends that its work be funded.

- Training should focus on prevention initiatives, such as student assistance programs, identification and referral, behavior management techniques, parent involvement, psychoeducational intervention strategies, and delivery of school-based mental health services.

- The Texas Education Agency should establish a task force to review recruitment, preservice education, certification, and retention of teachers of students with emotional disturbance.

- To ensure that school personnel are prepared to work effectively with students with emotional disturbance, at least eight hours per year of training should be required for all public school personnel (e.g., counselors, teachers, aides, diagnosticians, administrators) on strategies for teaching these children. This training should augment the work of the Interagency Training Group, and should be coordinated through the regional education service centers.

6. **The Joint Task Force recommends that all children with emotional disturbance who are eligible for special education and related services be identified and served appropriately. To ensure appropriate identification through the schools, standards for the Texas Education Agency accreditation or monitoring process should be developed and included in district reviews.**

Rationale: Children needing mental health services can be identified by any agency. Use of the interagency definition of emotional disturbance (see Appendix) enables children in different agency systems to receive services. Some of these students, but not all, will need special education. The 1988 report of the Joint Task Force contained recommendations to address the under-identification of students with emotional disturbance who do need special education services in the schools. Although research suggests that the actual special education prevalence rate of students with emotional disturbance should be 3-5%, the identification rate by school districts in Texas is only 1.1%. In 1988, the Joint Task Force recommended that by 1995, at least 2% of students be assessed to determine whether they are seriously emotionally disturbed.

To encourage this 2% assessment rate, three types of standards need to be incorporated into the monitoring or accreditation document of Texas Education Agency: (a) whether school districts have appropriate personnel on staff to identify children with emotional disturbance; (b) what percentage of students are identified with serious emotional disturbance; and (c) what types of related services are provided to the identified students. Currently only 25% of identified students with emotional disturbance are receiving any related services to provide counseling or psychological consultation to them or their families.

7. **The Joint Task Force recommends that legislators and decision-makers review new legislation that will affect children prior to its implementation to ensure that it will not result in conflicting mandates contributing to program inflexibility, fragmentation, or splintered services.**

Rationale: Mental health is fostered and emotional disturbance is prevented through service models designed to accommodate human variability and individual differences in children and their families or caregivers. Increased agency coordination and accessibility will encourage broad participation in prevention and early intervention services that have previously been difficult for consumers to obtain.

8. **The Joint Task Force recommends that legislation be enacted to assure that all agencies serving children develop appropriate and coordinated programs and services for children with serious emotional disturbance, and to mandate that the Texas Department of Mental Health and Mental Retardation include early intervention as a core service to high-risk children and families.**

Rationale: Until coordinated children's mental health services, both preventive and interventive, are established within the agencies that serve children, the current fragmented patchwork of expensive ad hoc services will be all that the state offers.

> *"We as parents continue to seek help, stay in close touch with physicians, read all the self-help books hot off the press, work as closely with teachers as possible, and take it a day at a time and pray the he will not become a high school dropout, look to drugs as a solution to pain or worse yet become a teenage suicide statistic. These are very real concerns for us."*
>
> Parent of 13-year-old boy with
> serious emotional disturbance

BACKGROUND

The "back-to-basics" philosophy of education clearly dominates the current educational reform movement. The individual child is both the target of the reform movement and its only hope. However, the degree to which broad policies reach individual children predicts the extent to which educational reform will actually occur. To learn, the whole child must be reached--thoughts and feelings included.

Children's feelings are gatekeepers to learning and achievement. For better or worse, children do not leave their feelings at home. Where acute family crises or chronic conditions of dysfunction, abuse, neglect, or genetic predisposition stand as a roadblock to learning, attending to the child's mental health becomes the only path to education

The demand for public services, evidenced by high rates of youth suicide, high rates of alcohol and other drug abuse, increasing disintegration of the family, and increasing numbers of children raised in poverty, is straining an already strained state budget. Efficient service delivery is more important than ever before.

The current system of care for children with severe emotional disabilities lacks a coordinated focus. Children frequently pass through one public agency system after another, with each agency operating in isolation. This is expensive, redundant, and ineffective. Few interagency coordinated services exist at the local level in Texas. Limited coordination efforts have been initiated through the implementation of Senate Bill 298 with community resource coordination groups, the Texas Department of Mental Health and Mental Retardation Children's Mental Health Demonstration Projects, and that department's Child and Adolescent Service System Program. These projects have improved the delivery of mental health services among child-serving agencies.

This report offers solutions: solutions that involve restructuring mental health service delivery to children with emotional disturbance and their families; solutions that call for more prevention and early intervention programs; solutions that require closely coordinated state and local interagency planning; and solutions that revamp the current funding pattern of services to children.

The Texas Education Agency was mandated by the 71st Texas Legislature in Senate Bill 417 to continue the Joint Texas Education Agency/Texas Department of Mental Health and Mental Retardation Task Force on Emotional Disturbance.

As part of its continuation, it was mandated to conduct a study to evaluate and make recommendations concerning:

"(1) the appropriateness and cost-effectiveness of residential placements of students with emotional disturbance;

(2) the creation of appropriate community-based networks of outpatient services for students who are emotionally disturbed who would otherwise be placed in a residential placement;

(3) the creation of a family-centered response and intervention system for students with emotional disabilities and their families; and

(4) early intervention and prevention strategies including early identification of students with emotional disabilities."

Definition of Emotional Disturbance

Broadly understood, severe emotional disturbances cause major impairments in functioning for an extended period of time. In general, behaviors and characteristics of emotional disturbance may include:

difficulty with tasks of daily life;

extreme vulnerability to stress;

increased tendency toward alcohol or other drug abuse;

tendency toward episodes of "acting out" that may be harmful to others;

serious depression possibly leading to ideas of suicide or suicide attempts;

lack of ability to develop friends; and

inability to function in school.

Environmental risk factors such as parental neglect, child abuse, poverty, parental alcoholism, or divorce place children at a higher risk of developing emotional disabilities than their peers. (See The Development of Emotional Problems in Children and Adolescents, Volume II.)

One of the major problems with coordinating services to this population is the variety of definitions for emotional disturbance. The educational system has a different definition than the mental health system. (See Appendix.) Some agencies have no definition at all, but leave eligibility decisions up to the referring psychologist or psychiatrist.

Recently, an interagency group of representatives from the Texas Education Agency, Texas Department of Mental Health and Mental Retardation, Texas Department of Human Services, Texas Juvenile Probation Commission, Texas Rehabilitation Commission, Texas Department of Health, and Texas Council on Alcohol and Drug Abuse adopted one definition for serious emotional disturbance. (See Appendix.) Adoption of this definition by the major agencies serving children is moving the state toward far greater uniformity, enabling agencies to coordinate and plan services to this underserved group of children and their families.

Prevalence of Emotional Disturbance in Children

The Office of Technology Assessment report from the 99th Congress (1986) states that of the nation's 63 million children under the age of 18, 12% or 7.5 million, have emotional problems which warrant intervention.[25] Conservative estimates indicate that 3-5% of the total population of children are seriously emotionally disturbed and in need of intensive mental health services. According to estimates from the Texas Department of Mental Health and Mental Retardation[26] in 1988, at least 578,072 children under the age of 18 in Texas have mental health problems that require professional mental health treatment. Some of these children are able to receive services with private insurance. However, approximately 100,534 children do not have this option and require services through the public sector. Of this 100,534, only 22%--22,000 children--are receiving public mental health services; virtually all services are provided with local funds. Seventy-eight percent are without help.

The present report looks only at the need for mental health services funded by public agencies, and not at the high costs of mental health services funded through private insurance.

The Joint Task Force, in its 1988 report, found that school districts were under-identifying children with serious emotional disturbance.[27] The identification rate of less than 1% of the total school-age population as seriously emotionally disturbed, when compared to the nationally recognized and conservative estimate of 3-5%, suggested that many students were not being identified and served by schools. While the identification rate has steadily increased since 1986 (see Table 1), the most recent data from 1989-90 indicate that school districts are now identifying 1.1% (approximately 39,627 students). This is still considerably less than the 3-5% estimated to be in need of services.

Table 1: Students With Serious Emotional Disturbance in Texas 1986-90

	1986-87	1987-88	1988-89	1989-90
Total number of SED students	31,596	33,682	36,840	39,627
Total special education population	379,623	393,480	411,783	425,493
SED percentage of special education	8%	8.5%	8.9%	9.3%
Total school population	3,337,593	3,366,194	3,398,808	3,470,853
SED percentage of total school population	.95%	1.00%	1.08%	1.14%

Costs of Care

Texas is spending millions of dollars for a small percentage of children in need. According to the report of the Mental Health Association of Texas (1989), Do Kids Count?,[28] Texas agencies are spending most of their public funds on the most restrictive care: residential placement.

The six agencies that serve the largest number of children with emotional or behavioral disabilities are the Texas Youth Commission, Texas Education Agency, Texas Juvenile Probation Commission, Texas Commission on Alcohol and Drug Abuse, Texas Department of Human Services, and Texas Department of Mental Health and Mental Retardation. The 1989 combined budget of these agencies (and the Texas Employment Commission) for services for these children was $92,624,094. Of this 65%, or $60,079,163, was spent on residential placements, largely through contracted services with private facilities. (See Table 2, and Figure 1.)

Developing Community-Based Services

Services to children continue to be fragmented, sporadic, and restrictive. Seventy percent of respondents to a Joint Task Force survey reported that the lack of community-based services was the primary reason for placing students in residential programs; there were no other options. National studies indicate that the current level of community-based services throughout the country are inadequate.[29]

Community-based services can be described in terms of the major types of care that should be available to children with emotional disturbance and their families.

Table 2

Residential Placement Costs to Texas for Youth With Emotional Disturbance

AGENCY	YEAR	# YOUTH WITH ED	TYPE OF FACILITY	AVE. LENGTH OF STAY	$/YOUTH/ AVE. LENGTH	TOTAL COST/YEAR
TDHS	1989-90	246	*Contracted RTC (level 4)	365	$7,605	$1,870,832
		1,184	(level 5)	365	$14,069	$16,657,585
		1,430				$18,528,417
TDMHMR	1988-89	1,322	Inpatient hospitalization	64 days	$12,966	$22,800,799
	1988-89	243	Waco Center for Youth	128 days	$23,750	$5,771,241
	****1989-90	not available	Contracted residential care	not available		$846,000
		1,565				$29,418,040
TEA	1989-90	64	Contracted RTC	365 days	$80,588	$5,157,642
TYC	****1989-90	398	Contracted RTC (level 5)	not available		$3,200,000
	1988-89	88	Corsicana Treatment	359 days	$42,898	$3,775,064
		486				$6,975,064
TJPC	Data not available.					
GRAND TOTAL		**3,545			$30,312	$60,079,163

* Contracted residential treatment centers are at levels 4, 5, or 6.

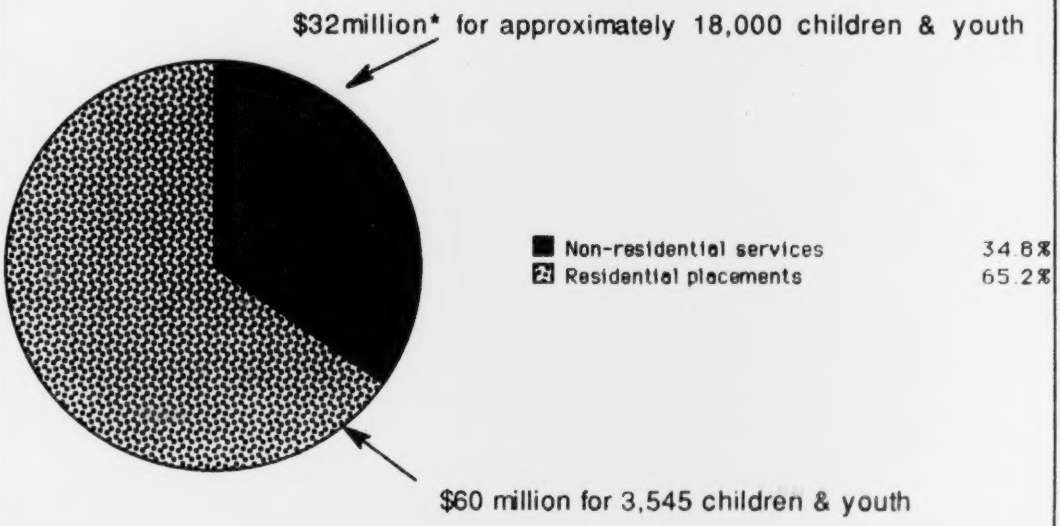
** Client count may be duplicated, so final estimate of cost per child may be underestimated.

*** TDMHMR figures for inpatient hospitalization reflect direct care costs plus an estimated 25% for support and administrative costs.

**** Figures are for estimated number of youth served during the 1989-90 year.

*****TJPC does not collect this information specifically for youth with emotional disturbance. In 1988, juvenile probation departments spent $6,549,158 on 1,978 juvenile offenders for out-of-home placements other than foster care purchased in the private sector. The Joint Task Force estimates that 25% of these juvenile offenders may have had serious emotional problems.

Figure 1: Proportion of Total Texas Mental Health Budget Allocated for Residential and Non-Residential Costs (FY 1989)



*Only 6%, or $2 million of the funds for community-based services were provided by TDMHMR; the remaining 94%, or $30 million, of funds for community-based services were provided by six separate state agencies (TYC, TJPC, TCADA, TEC, TDHS, and TEA.)

The paper, A Comprehensive System of Care, delineates and describes the components of an ideal system of care for children with emotional disturbance. (See Volume II.) This paper is based on recommended models found in the literature and on the best thinking by members of the task force. The system described in this paper is founded on two assumptions: that the child and family, not agency configurations, should drive necessary services, and that the majority of the services should be community-based.

If accountable community-based services were available, the resulting continuum of care would reduce dependency on more costly residential treatment and would allow the delivery of services at the appropriate levels of need. The annual estimated cost per child in need of public mental health services to provide a full continuum of care is $3,474. (See Table 3.) Alternatively, the average annual cost per child for residential treatment is $30,000. In many cases, the delivery of early intervention services on the continuum would circumvent the need for more intensive and expensive treatment (i.e., residential placement) down the road.

Table 3: Estimated Cost Per Child in Need of Public Mental Health Services Proposed Continuum of Care Alternative

An estimated*:	May need:
1%	residential treatment @ $30,000 average cost per length of stay
4%	crisis stabilization @ $8,820 average annual cost
4%	medication-related services @ $1,000 average annual cost
24%	school-based integrated psychoeducational programming including group, individual counseling and family support services @ $3,838 average annual cost
35%	psychoeducational programming, including group or individual counseling @ $1,200 average annual cost
36%	may need weekly professional time and case management @ $2,000 average annual cost

Average Cost Per Child: $3474

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*based on a 1990 estimate from TDMHMR

Percentages do not add to 100 due to overlapping service needs.

The service components in Table 3 are described in A Comprehensive System of Care, which provides a model for developing the recommended Comprehensive Community-Based Children's Service Plan.

ADDRESSING THE LEGISLATIVE MANDATES

The Joint Task Force has completed its studies as mandated by the 71st Legislature. To address the four components listed on page 10, data were collected on the following issues:

1. cost analyses of all public agencies that residentially place children with emotional disturbance (Texas Education Agency, Texas Department of Mental Health and Mental Retardation, Texas Department of Human Services, Texas Youth Commission, Texas Juvenile Probation Commission);
2. residential facility costs and services used by the Texas Education Agency, Texas Department of Mental Health and Mental Retardation, and Texas Department of Human Services for children with emotional disturbance;
3. inpatient treatment study of services on hospitalized children served through the Texas Department of Mental Health and Mental Retardation;
4. outcomes of children with emotional disturbance who are residentially placed by school districts;
5. availability of community-based services as reported by parents of children with emotional disabilities, special education administrators, and mental health agency administrators; and
6. prevention strategies used by school counselors throughout the state.

In addition to the data collection studies, the Joint Task Force comprehensively researched:

1. preventive student assistance programs;
2. preventive comprehensive school-based programs;
3. intensive school- and home-based treatment programs; and
4. the development of a continuum of services for children and families.

The complete findings from the data collection activities and comprehensive research are contained in Volume II of this report. The major findings from the studies are summarized and discussed here.

"They 'took us' for all the insurance money we had, and have given us no information. He was in the facility for 60 days, and then they waited until the last week to run tests, including a 'brain mapping' test, and we didn't get the results of that test or any of the other tests--nor did anyone else get that information. We feel we were taken advantage of."

Parent of 9-year-old boy with serious emotional disturbance

Mandate 1: Evaluate the Costs and Appropriateness of Residential Placement

To address this first mandate, the Joint Task Force studied:

a. the overall costs to the state for residential placements of children with emotional disturbance;

b. inpatient treatment costs to the Texas Department of Mental Health and Mental Retardation;

c. types and costs of services available through residential facilities approved by the Texas Department of Human Services, Texas Department of Mental Health and Mental Retardation, and Texas Education Agency; and

d. outcomes of residential placements of students with emotional disturbance by school districts for 1987-1990.

Overall Costs

Residential placement is the most costly and restrictive care that children with emotional disturbance can receive. The state is paying $60 million per year in public dollars for this care. A complete cost breakdown per agency is on Table 2.

The U.S. Government Commission on Children, Youth, and Families, using data from the National Institutes of Mental Health, estimates a 17% per year increase in the number of children placed in residential facilities to receive treatment for an emotional disorder.[10] This will result in an exponential increase in the costs to the state. The additional costs for 1990-91, using this estimated 17% increase, could total $18,278,136; for 1991-92, $21,369,960. (See Table 4.)

Table 4: Projected Increases in Costs for Residential Placements of Children with Emotional Disturbance (ED)

	1989-90	1990-91	1991-92
# of children with ED in residential placement	3,545	4,148*	4,853
projected additional costs		$18,278,136**	21,369,960**

* Based upon National Institute of Mental Health estimates of a 17% annual increase in number of youth with emotional disturbance in residential placements. Cited in the Select Committee on Children, Youth, and Families Report, "No Place to Call Home," U.S. Government Printing Office, Washington, DC, 1990.

** Based upon Joint Task Force estimates of average costs per youth per average length of stay in residential placements. Costs to the state average $30,312 per youth per average length of stay.

The Joint Task Force analyzed current costs for all mental health services from seven agencies, both residential and non-residential, to children with emotional problems. These services and costs per agency are listed on Table 5. The cost to the state for fiscal year 1989 was $92,624,094; 65% paid for the most restrictive care, and only one-third for non-residential, community-based services.

Non-residential services, listed on Table 5, include a wide array of mental health programs for children and families, but are available only to the population specified by each agency's definition of service need. Because each agency defines its target population differently, the services available are fragmented and uncoordinated, and many children simply do not receive services.

Inpatient Treatment Study

To explore trends in inpatient care offered by the Texas Department of Mental Health and Mental Retardation over the past three years, data on the six state hospitals with units for children and adolescents[11] and Waco Center for Youth were collected and analyzed. (See Table 6.) Texas Department of Mental Health and Mental Retardation data are presented for the following:

1. number of youths up to 18 years of age with a mental health diagnosis who were served by the department;

2. the total number of beddays; and

3. the overall costs for fiscal year 1989.[13]

Table 5: Residential and Non-Residential Costs by Agency for Children, Fiscal Year 1989

Agency	Services	Cost
Texas Youth Commission	Contracted Care Services	$ 9,943,577
	Psychological/Psychiatric Services Through Institutions	288,172
Texas Education Agency	Residential Costs	5,157,642
Texas Juvenile Probation Commission	State Aid to Counties	12,015,963
	Challenge Grant	750,000
Texas Employment Commission	Communities in Schools	3,591,766
Texas Commission on Alcohol & Drug Abuse	Prevention	1,974,945
	Intervention	3,640,734
	Outpatient Treatment	368,439
	Residential Treatment	1,815,600
Texas Department of Human Services	Children's Trust Fund	907,117
	Community Treatment	
	Assessment	1,240,616
	Outpatient Treatment	5,709,600
	Residential Treatment	18,000,000
	Alternative Treatment	1,669,578
	Services to Truants	2,550,345
Texas Department of Mental Health and Mental Retardation	Community Services	2,000,000
	Residential & Inpatient Treatment	21,000,000
	TOTAL	$92,624,094

Information obtained from the Mental Health Association of Texas report, Do Kids Count: How Texas Serves Children and Adolescents with Severe Emotional Disturbance, November 1989. Sixty-five percent of these costs are for residential (i.e., out-of-home) placements.

Table 6: Summary of Texas Department of Mental Health and Mental Retardation Children and Adolescent Inpatient Data, Fiscal Year 1989

Hospitals	Clients	Beddays*	Length of Stay	Cost/Day**	Total Cost
Austin	311	22,597	73	$212.20	$ 4,795,083
Big Spring	118	5,877	50	261.21	1,535,131
San Antonio	297	9,534	32	225.71	2,151,919
Terrell	213	19,397	91	224.66	4,357,730
Vernon	621	47,671	77	155.14	7,395,679
Wichita Falls	263	11,597	44	221.20	2,565,256
Waco Center	243	31,085	128	185.66	5,771,241
TOTAL ***	1,565	147,758	94	$212.25 (average)	$28,572,040

* Beddays refer to the number of nights that a client is physically present in a state hospital, unless a client comes in and leaves the same day, which then counts as one bedday.

** Original cost/day figures did not include fringe benefits for employees An estimated figure of 25%, supplied by the Texas Department of Mental Health and Mental Retardation was added on.

*** Total number of clients does not add up due to some clients being admitted to more than one hospital.

These data from these seven state institutions represent the most restrictive alternative. The task force focused only on this most restrictive alternative for three reasons. First, the cost of providing care for this population is paid by the state and therefore, affects the pocketbooks of all Texans. Second, this is most likely the least expensive inpatient treatment available in the state. If it can be shown that large sums of money are spent in these public institutions, it should become apparent that even greater amounts are spent for private care. Third, no other data were as specific, accurate, and reliable as the Texas Department of Mental Health and Mental Retardation Client And Registration (CARE) System data.

Of the 12 state hospitals and centers, eight have specific units for children and/or adolescents. Only four have both children and adolescent units. This severely limits the number of places to which a child requiring inpatient care can be referred. It also means that in many cases, a youth must travel far from home to be admitted into a children or adolescent unit.

Basic trends. There has been a consistent increase in the number of children and adolescents served in the state hospitals studied over the past three years. The increase has been over 18% since fiscal year 1987.

The age group most often found in state hospitals is the 16 to 18 year age category. However, the group aged 12 to 15 is close behind. Less than 1% of those served are under six-years-old. Nonetheless, there are still some children of this age group who are admitted for inpatient treatment.

Vernon State Hospital admitted the largest number of youth (621) of those explored in this analysis. Vernon is followed by Austin (311), San Antonio (297), Wichita Falls (263), Terrell (213), and Big Spring (118). Waco Center for Youth served 243 children and adolescents for fiscal year 1989.[14]

Bedday totals. Vernon State Hospital has the largest number of beddays accumulated for adolescent units compared to the other state hospitals. Waco Center for Youth had the second largest accumulation of beddays for this population.

For all state hospitals serving children and adolescents, there has been a slight decrease in beddays over the past three years (less than 2%). (See Table 7.) Over the same time period there has been an increase in the number of children and adolescents admitted to state hospitals in Texas.

Table 7: Children and Adolescent Clients Served and Beddays Used, Fiscal Year 1987-Fiscal Year 1989

Fiscal Year	Clients *	% Change	Beddays	% Change
1987	1,282	--	148,392	--
1988	1,357	5.5%	150,093	1.1%
1989	1,565	13.3%	147,758	-1.6%

* Persons 0 to 18 with a mental health diagnosis in the children and adolescent units of the Texas Department of Mental Health and Mental Retardation Inpatient Units.

Cost data. The average cost per day for the institutions ranged from $155 (Vernon State Hospital)[15] to over $260 (Big Spring State Hospital).[16] Interestingly, Vernon, with the lowest bedday rate, spent the most on bedday costs for youth in fiscal year 1989 while Big Spring, with the highest bedday rate, spent the least on beddays for youth in fiscal year 1989. One explanation for this is that some hospitals had more patients of this age group than the other institutions and therefore, more beddays to drive up overall costs for these institutions, no matter what the daily bedday rate.

The average cost for children and adolescent units of state hospitals is approximately $212 per day. Inpatient care for children and adolescents is more expensive than other units of these same state institutions (approximate average cost is $150 per day).

The average cost per day in the Waco Center for Youth (just over $185 per day) is over 40% lower than the most expensive per day state hospital. The reason for this difference in cost per day is not readily apparent. One thing is clear: the setting at Waco is structured for youth, unlike all other state hospitals that focus on the care and treatment of adults and offer a separate unit for children and adolescents. It may be that a more efficient system results when the entire campus of a hospital is devoted to serving youth.

The total cost for the Texas Department of Mental Health and Mental Retardation to provide inpatient care for children and adolescents in fiscal year 1989 was almost $28.6 million. Although this figure is quite large, it does not include private insurance costs, which would make the total state expense even larger.

Residential Facility Study

To help evaluate the appropriateness and cost-effectiveness of residential placements, descriptive information was gathered about residential facilities serving Texas children. Specifically, information was collected pertaining to populations served, level of services provided, and cost.

A data collection instrument (see Volume II) was designed by the Joint Task Force and sent to 138 public and private in-state residential facilities which serve school-age children. Information for analysis was gathered from this survey and from the Texas Network for Children database.

Services Provided to Youth in Residential Placement. Most facilities report they provide a full range of psychological services.

Table 8: Percent of Facilities Providing Specific Core Services

Type of Service	Percent Providing
Individual Counseling	100%
Group Counseling	100%
Family Counseling	93%
Medication Management	98%
Individual Behavior Modification	80%
Group Modification Program	91%

Table 9 : Counseling Services Provided

Individual Counseling	Mean:	2.2 hours per week
	Median:	2.0 hours per week
	Range:	0.5 to 6.0 hours per week
Group Counseling	Mean:	7.0 hours per week
	Median:	5.0 hours per week
	Range:	4 to 42 hours per week
Family Counseling	Mean:	1.5 hours per week
	Median:	1 hour per week
	Range:	0 to 10 hours per week

Therapeutic orientation of facility staff. Therapeutic orientations were eclectic rather than exclusive with virtually every combination of therapeutic orientations reported.

Table 10: Staff Therapeutic Orientation

Most Frequent Responses	Therapeutic Orientation	Number	Percent
Most Frequent Orientation	**Behavioral**	34	77%
Most Frequent Combinations of 2 Therapeutic Orientations	**Behavior/Family-Centered**	25	57%
	Family-Centered/Systems	25	57%
Most Frequent Combination of 3 Therapeutic Orientations	**Behavior/Systems Family-Centered**	23	52%

Note: Respondents tended to check orientation, rather than ranking as requested

Cost data. The average cost per day for placement in for-profit residential facilities is nearly 400% higher than the average cost per day in not-for-profit residential facilities. While actual costs per day for both types of facilities occupy the range between $200 and $600, only not-for-profit facilities occupy the $0 to $200 range and only for-profit facilities occupy the $600 to $900 range as shown in Table 11. In addition, 75% of the not-for-profit facilities have per day costs less than $200.

Table 11: Cost Per Day for Residential Placement

Summary Data	Not-for-Profit Facilities	For-Profit Facilities
N	41	34
Average Cost/Day	$ 127	$ 489
Median	$ 95	$ 450
Range	$58-$413	$235-$830

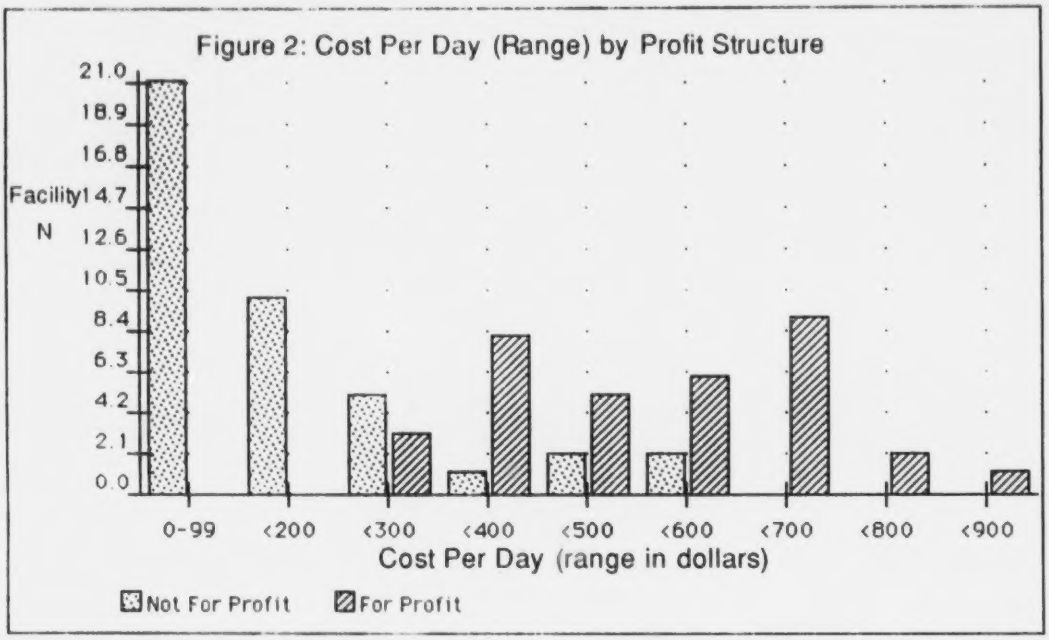


Figure 2: Cost Per Day (Range) by Profit Structure

Table 12: Recommendations Typically Made for Follow-Up Treatment

Type of Treatment Recommended	Frequency Recommended	Percent Facilities Recommending
Individual outpatient therapy	28	64%
Family outpatient therapy	19	43%
Continue aftercare program of hospital	8	18%
Possible out-of-home placement	7	16%
AA/NA/substance abuse & other support groups	6	14%
Medication/physician follow-up	5	11%

Outcome Study of Residential Placements

This study specifically addressed the discharge outcomes for students.

Focusing upon the residential placements by school districts of students with serious emotional disturbance during the 1987-90 school years, a data collection instrument (see Volume II) designed by the Joint Task Force was sent to all directors of special education in whose districts at least one student with emotional disturbance had been placed residentially. Information was gathered both from Texas Education Agency residential records and from the directors of special education who completed the instrument and from telephone interviews. Districts that did not respond to the initial instrument were contacted by telephone for follow-up.

School districts placed 114 students with emotional disturbance in residential treatment during the 1987-90 school years. These placements were funded by a combination of state, federal, and local funds. A complete breakdown of the costs by category for these residential placements is in Volume II.

Major findings from this study are described below.

Statewide distribution of students in residential placement. In the last three years, 6% of Texas school districts (59/1068) have placed students with emotional disturbance in residential treatment. These districts lie within 17 of the 20 education service center regions. Four regions (IV, VI, XIII, XX) account for 73% of all placements.

Length of stay. The average length of stay in residential treatment for these students is 18.2 months, with a median of 15 months and a range of 3 to more than 60 months. Data were not available for more than a 60-month placement.

Facilities used. A small number of facilities are used by districts in which to place students. Specifically, five facilities account for 59% of all placements. One facility accounted for 34% of all placements. This facility also has the longest placements of any other used by districts: 77% of all placements three years or longer and all placements five years or longer.

Age and grade characteristics. The average age of the student when placed is 13 and the average grade is seventh.

Cited reasons for placement. The major reasons cited by the directors for placement were, first, that the student exhibited major behavior problems including violence, assaultiveness, or suicide attempts and, second, alternative treatments had either been exhausted or were not available.

Services that would have prevented placements. Over two-thirds of respondents stated that the student would not have been placed if community-based services for the student and family were available. Services that were mentioned included day treatment, respite care, intensive in-home family support, and crisis stabilization.

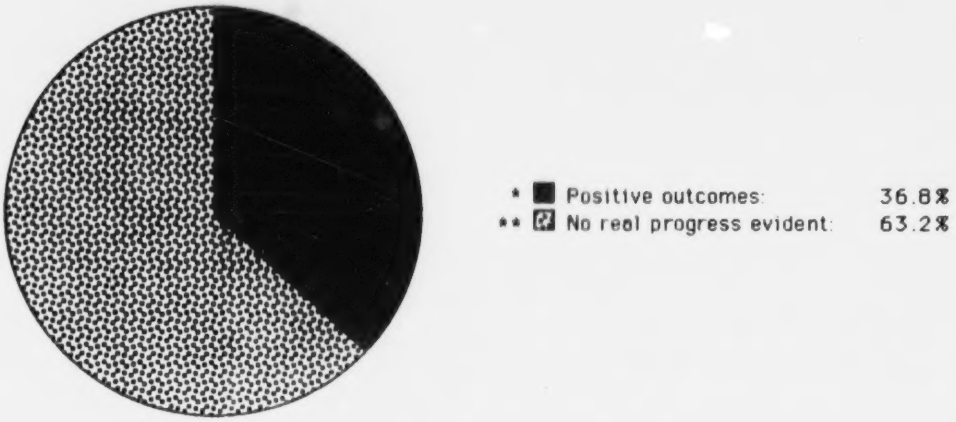
Cost figures. The average cost per month per youth is $6,316, with a range of $763 to $15,893. A complete cost analysis by facility is in Volume II.

Outcome information. Outcomes of students residentially placed by districts were determined for 100% of the students as shown below.

Positive outcomes. In 36% of the cases, positive results were evident. These students included those discharged with positive results, and those still in residential placement who had made substantial progress. "Discharged with positive outcome" was defined by the determination that the student was back in school, in vocational training, or working.

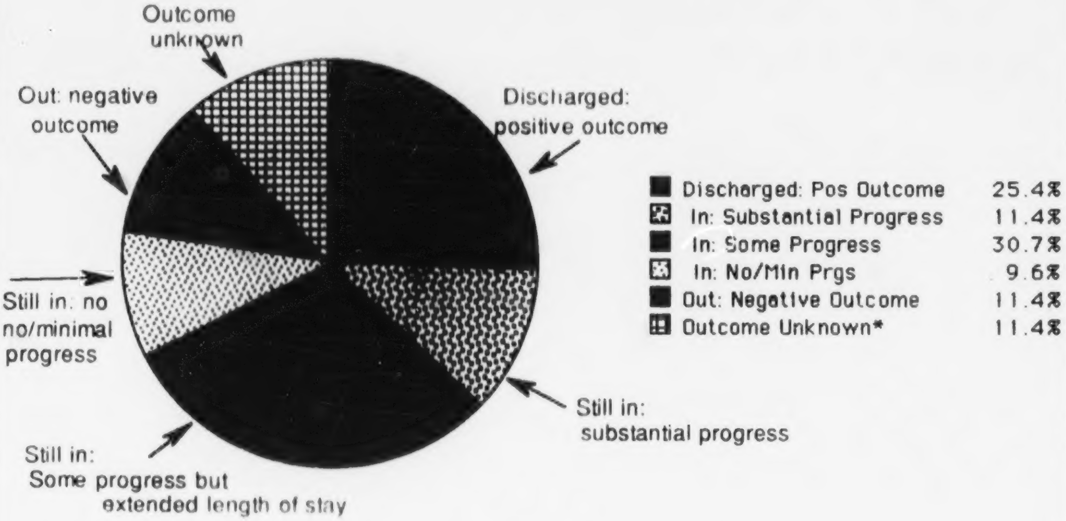
Other outcomes. In 63% of the cases, outcome was negative. The students had made only some progress with a high average length of stay (22 months), had made no or minimal progress, were out of the facility with a negative outcome, or their outcomes were unknown.

Figure 3: Orientation of All Outcomes



* Discharged with positive outcome; Still in with substantial progress
** Still in with some progress; Still in with no/minimal progress; Out with a negative outcome (ran away, set fire and discharged, parents removed and problems persist, etc.); outcome unknown

Figure 4: Specific Outcome Categories



Specific outcome categories.

- One-fourth of the students were reported to have been discharged with positive results.
- Eleven percent of the students were still in residential placement and had made substantial progress.
- Of the students still in placement, 31% were classified as showing some progress but had been in treatment for an average length of stay of 22 months.
- Of the students still in placement, 10% showed no or minimal progress.
- Eleven percent were classified as no longer in placement with a negative outcome, meaning they set fires, ran away, etc.
- Eleven percent of the students and/or their families could not be located and were classified as "Outcome Unknown."

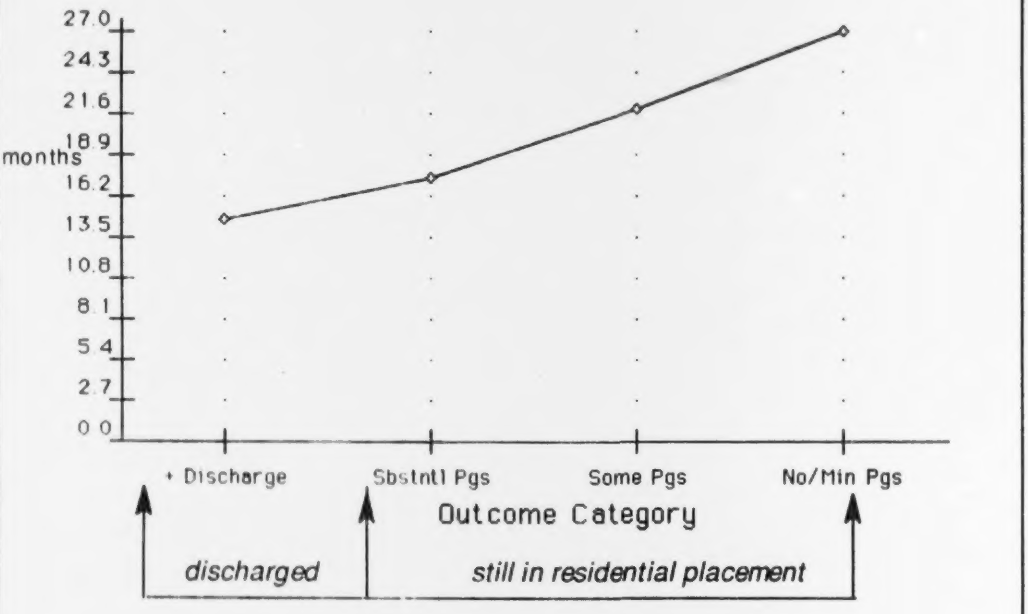
Analysis of the outcomes within the five major facilities that receive district placements is located in Volume II.

Relationship between length of stay and outcome. Analysis indicated that the more negative outcomes are associated with longer lengths of stay. The shorter the length of placement, the greater likelihood of a positive discharge. Conversely, the longer the length of placement, the greater likelihood of negative outcomes. A student with emotional disturbance is more likely to be discharged with positive outcomes back to school and home, if that student is returned home within a short time frame (i.e. average of 14.7 months). The longer the student remains in residential placement, the less likely he or she will be discharged with positive results.

Table 13: Average Length of Stay (in months) by Outcome Category

Outcome	+Discharge	Substantial Progress	Some Progress	No/Minimal Progress	Neg	Unknown
N	29	13	35	11	13	13
Mean	14.7	17.4	21.9	27	36	27

Figure 5: Mean Lengths of Stay by Outcome Category



The availability of community-based resources for students returning to the district is the most likely reason for the association between positive discharge and shorter length of stay. Interviews with special education directors and staff indicate that when these students were positively discharged, they continued treatment and education in school district programs and through community services that accommodated their needs. Thus, the possibility can be inferred that where community-based services are available, students can return home sooner than students who must remain in residential placement to receive appropriate mental health services.

Presenting problems of the students with positive discharges include a wide range of severe pathology including depression, suicidal ideation, schizophrenia, dangerous and aggressive behavior, violence, weapon use, running away from home and out-of-control behavior at home and school. At this time, preliminary analyses do not support an association between positive discharge status and less severe pathology.

District characteristics and positive discharge. Positive discharge is more likely when students return to districts that are large. Districts with more than 10,000 average daily attendance were the most likely to bring home students whose outcomes were positive. This may result from the greater availability of community-based resources within the larger cities containing these districts.

Relationship between cost per month and outcome. There is no relationship between cost per month and outcome. The different outcomes are evenly distributed throughout the range of costs per month. Thus, the possibility that less expensive residential treatment could produce the same outcome as more expensive residential treatment needs further investigation.

> *"It is sickening that adolescent problems have in the last decade become such a big money making business. The norm seems to be 'yes, your child definitely needs help and we're the ones to provide it' but as soon as the insurance and/or personal funds run out he or she is miraculously 'cured' and returned to school/society to sink or swim."*
>
> Parent of 13-year-old boy with
> serious emotional disturbance

Mandate 2: Address the Creation of Community-Based Services

Non-residential alternatives are available only to a limited extent in Texas and are administered through various agencies. Research shows that a complete system of care should be available to children to prevent emotional problems from developing and to intervene effectively when emotional difficulties do occur. A sample of a comprehensive system of care is described in Volume II. In addition to services provided by schools, the basic services needed within each community include the following.

Prevention:	Strategies to reduce or prevent the incidence of new problems through early identification, diagnosis, and treatment.
Early Identification and Intervention:	Screening programs for early recognition to reduce the duration and severity of mental health problems and reduce the overall prevalence of emotional disturbances in children.
Assessment:	The professional determination of the nature of a child's or family's problems in the context of environmental demands.
Respite:	Home-based or center-based care to provide relief and support to families.
Outpatient Treatment:	Services usually provided in a community mental health setting, hospital, or in some cases, schools. Services include therapy, medication management, social skills training, parent training, and social support.
Home-Based Services:	Intensive support services provided to children and their families in their own homes, usually time-limited and focused. While these services do not eliminate the need for residential care in all cases, they do provide a non-residential and intensive alternative to hospitalization and other forms of residential treatment.

Day Treatment:	Services that provide education in an integrated program of counseling and family services involving a child during the school day or extended day. Day treatment usually includes special education, counseling, crisis intervention and problem-solving training.
Crisis Services:	Center-based or home-based interventions that are provided on a 24-hour basis and that are short-term and immediate.
Case Management:	Includes brokering services for children, advocating on their behalf, and coordinating treatment planning, implementation, and evaluation.

While some of these services are available to some children, most public funds for children with emotional disturbance are directed toward residential care, not toward non-residential, community-based services. In addition, as noted, 78% of the children with serious emotional problems are not receiving any public mental health services.

To address the second mandate--the creation of community-based services for children with emotional disabilities--the Joint Task Force conducted:

a. a survey of Child and Adolescent Service System Program (CASSP) key informants; and

b. a survey of the Texas Council of Administrators of Special Education.

Child and Adolescent Service System Program (CASSP) Key Informant Survey

In the summer and fall of 1989, the staff of CASSP at the Texas Department of Mental Health and Mental Retardation surveyed the directors of the 35 community mental health centers in Texas to determine the kinds of community-based services now available and those needed to serve children with emotional disturbance and their families.

The major findings as reported by center staff include the following.
- Day treatment is not available at 94% of the centers.
- Case management is not available at 73% of the centers.
- Outpatient counseling is not available at 49% of the community centers.
- Family therapy is not available at 33% of the centers.
- Identified child mental health workers are not available at 30% of the centers.

In addition, the following were identified as the main service needs for their community centers.

Table 14: Community Mental Health Center Major Service Needs

Service	Percentage Identifying
Crisis stabilization	41%
Additional staff	38%
Residential beds	33%
Day treatment	22%
Respite care	16%
Case management	11%

Administrators' Survey

The Joint Task Force conducted a written survey of directors of special education programs in Texas public schools to determine local school administrators' awareness of (1) the current availability of services for students with emotional disturbance and (2) the charges of the Joint Task Force. Respondents to the survey were asked to describe the "community-based networks of outpatient services" available in their areas for students with emotional disturbance who would otherwise be in residential placement.

Major findings concerning services available throughout the state include the following.

- Almost half of the respondents indicated that no "community-based networks of outpatient services" exist in their areas.
- According to 21% of the respondents, mental health centers represented the community-based network of outpatient services in their areas.
- Of the respondents, 15% stressed that the available mental health center services were "minimal to non-existent" or extremely difficult to access due to exclusions of school-age children, prohibitive distance to services, long waiting lists, and lack of funding and adequately trained service providers.
- According to 12% of the respondents, only private psychiatric hospitals were providing community-based services in their areas. Comments were made about the prohibitive costs and exclusive nature of these services.
- Over 80% of the respondents noted that no interagency agreements had been established between the local education agency and local or area mental health agencies.
- Over 70% of the respondents acknowledged that no "family-centered response and intervention system" was available for students with emotional disabilities and their families.

When given the opportunity to provide recommendations for the Joint Task Force, the recommendations focused on:

- the need for interagency cooperation and expansion of community services for children and their families, and for improved parenting skills through family-oriented services (43% of responses);
- the need for improved staff development and school administrator/teacher training about programming for children with emotional disorders (19% of responses);
- the need for improved diagnostic procedures, policies, and practices for identifying emotional disturbances, behavior disorders, attention deficit disorders, and social maladjustment (19% of responses);
- the need for increased funding for school districts to implement prevention and intervention strategies and to develop alternatives for residential care in concert with mental health agencies (15% of responses); and
- requests for the task force to provide ideas or recommendations for establishing service networks in local communities, placement alternatives for extremely aggressive students, and service delivery for rural areas with limited resources and low incidence populations to serve (4% of responses).

The overall focus of survey responses centered on special education directors' perceptions that schools "are not getting much help from the outside" for children with emotional disabilities and that ancillary services are often nonexistent in local communities. Further, school administrators relate limited access for families to mental health services as well as perceived lack of accountability on the part of other agencies. There is an evident need for guidance from the Texas Education Agency and from mental health centers in establishing interagency agreements to alleviate these valid concerns.

> *"Parents are willing to try anything and without guarantees when they are emotionally drained by an emotionally disturbed child--the schools and families must be made to understand that they can work together, plan individual education plans together (for home and school) and see improvement in a child's performance/behavior without residential treatment costs and stigma."*
>
> Parent of son with
> emotional disturbance

Mandate 3: Study the Creation of a Family-Centered Response and Intervention System

In investigating a family-centered response and intervention system, the task force found that such a system does not exist. Agency task forces and committees are beginning to acknowledge and involve parents who can articulate the effects of public policy upon the population served. Parents of children with emotional disorders are becoming more willing to work with public agencies on behalf of the treatment and support services that their children need.

The Texas Department of Mental Health and Mental Retardation, through its Children's Mental Health Demonstration Projects, has funded five family preservation models which include respite care, intensive therapy for families within their homes, and flexible funding to purchase other supportive services. Case workers have small case loads and help coordinate services between schools, courts, and other social service agencies.

To address the third component of the legislative mandate, the Joint Task Force:

a. reviewed common family treatment models through institutes and universities in Texas that include school-based services; and

b. surveyed 120 parents of children with emotional disturbance to ascertain the level of services received and needed by these families.

The results of these activities are briefly discussed below. A complete description is in Volume II of this report.

Family Treatment Models

To investigate the level of involvement of parents whose children have emotional disabilities, experts in the field of family treatment were invited to discuss their programs. Each program includes a school-based component. Three types of models are available to a very limited extent in Texas: (1) university-affiliated programs; (2) institute/school contracts for family services; and (3) brief family/school mediation meetings.

The first model, a university-affiliated program, is offered at Our Lady of the Lake University in San Antonio. Families are referred to the program by schools, courts, or social service agencies. A full range of treatment is provided, including individual, couple, and family therapy. A sliding fee scale is available for clients unable to pay the full fee. Typical problems that are treated include substance abuse, marital violence, depression, suicidal tendencies, child abuse, and behavioral problems within the school setting.

The second model is typified by programs offered at the Galveston Family Institute, the Southwest Family Institute in Dallas, and the community counseling service program at Our Lady of the Lake University. In these models, school- or home-based therapeutic services are offered to families and include consultation with teachers, weekly family therapy, group counseling, and psychological assessment. In addition, training is provided to school staff on clinical issues.

The third model entails brief, solution-focused meetings between family members and school staff. Operated as an outreach service from a university or institute, this family-systems model focuses on categorizing solutions rather than problems. In one project, offered through The University of Texas at Austin, families of children with emotional or behavioral problems are brought together with school staff (i.e., principals, teachers, and counselors) with the explicit purpose of solving a specified problem. The focus of this model is not to treat family problems but to problem-solve specific factors that are interfering with family and school functioning.

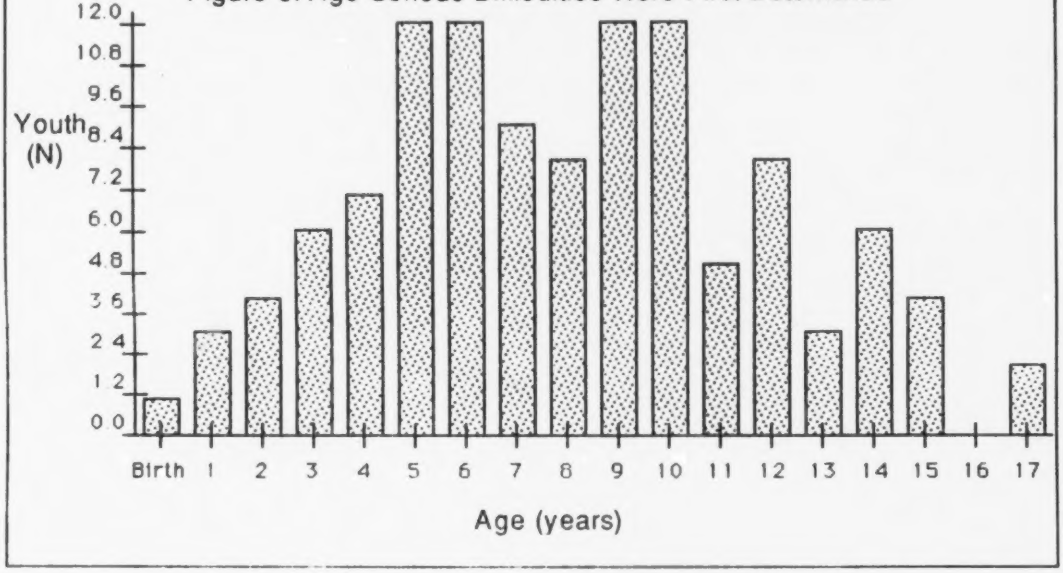
An outside consultant, a trained family intervention specialist, meets with school staff and the family once to focus on what can be changed. Follow-up is provided through consultation with school staff. The principle of the family/school mediation meetings is to problem-solve as early as possible and focus upon that which can be changed.

Parent Survey

One hundred-twenty parents or guardians of children with emotional difficulties responded to a data collection instrument designed by the task force and distributed through the 20 regional education service centers in July 1990. Completed surveys were anonymous and were returned directly to the task force. Effectively, every child was receiving or had received services in special education at school.

Age serious difficulties were first determined. The age-range during which serious difficulties were first determined appeared to lie between 5 and 10 years of age.

Figure 6: Age Serious Difficulties Were First Determined



Person(s) who first determined serious difficulties. It is clear that parents were among the first to determine serious difficulties. It is also clear that schools played a major role in determining serious difficulties. It is not clear whether or not the "psychologist" was school affiliated or a private provider.

Table 15: Persons Who First Determined Difficulty

Persons	N	Percent
Parents	56	47%
Psychologist	53	44%
Teacher	51	43%
School counselor	42	35%
Psychiatrist	24	20%
Private MD	14	12%
Other School Staff	11	9%
Principal	2	
CPS	2	
Juvenile Authority	3	
Grandparents	2	
MHMR, DHS	2	
ESC	1	
Social Worker	1	

Services received from all sources. Direct therapeutic services were the primary services received.

Table 16: Services Received (frequency) as Reported by Parents

Type of Service	N	Percent
Individual Therapy	89	74%
Family Therapy	56	47%
Medication Management	44	37%
Parents Support Group	26	22%
Sibling Therapy	17	14%
Individual Support Group	13	11%
Respite Care	5	4%
Sibling Support Group	2	2%
Family Monitoring	1	1%
Therapeutic Horseback Riding	1	1%
None	6	5%

Service providers. Clearly, private providers delivered most of the services (59%) for youth.

Table 17: Major Service Providers

Private	41%
ISD/Coop	16%
MHMR	15%
Hospital In-P	14%
Hospital Out-P	9%
Community Non-Profit	5%

Perceived adequacy of services. A clear majority of parents (72%) felt that services were adequate only to some degree or not adequate at all. Roughly 27% felt that adequate services were available for child and family or for child only.

Table 18: Are Adequate Services Available?

Parental Perceptions	Percent
No	41
To some degree	31
Yes, for child & family	25
Yes, for child only	2

Table 19: Services Desired: Open-Ended Parent Responses (frequency)

Type/Nature of Service Desired	N	Percent
Psych/Counseling Services		
Counseling: child/family/individual	25	21%
Equally accessible/affordable psychological services	13	11%
Emergency counseling/crisis intervention	6	5%
Accessible MHMR services	6	5%
Alternative/Expanded Care Services		
Respite Care: any and more	12	10%
Before & after school daycare, activities/supervision	9	8%
Specialized daycare/activities for disabled	5	4%
School Related		
Increased teacher/diagnostician training	9	8%
Vocational teaching/expanded curriculum	6	5%
Support Groups/Non-Professional Training		
Parent support groups	12	10%
Teen/youth support groups	6	5%
Parent training	3	3%
Other		
Networking of services, comprehensive listing & referral, ombudsman/info sharing	5	4%
Help in general	3	3%

Case management. In nearly 70% of cases, school special education staff served a case management function for youth with serious difficulties. Parents clearly viewed the school as the hub of services for children with serious difficulties.

Table 20: Case Management: Reported Providers (frequency

Provider	N	Percent
Parents only	15	13%
Parents in combination with one or more below:		
Special education staff	81	68%
Private provider	27	23%
MHMR staff	16	13%
Private physician	14	12%
Another family member or friend	9	8%
Other	9	8%

Of the 120 parents who responded to the Joint Task Force survey, 42% had children who had been residentially placed. The following findings came from these parents.

Number of residential facilities in which placed. A total of 45% of children had been in more than one residential facility. Twenty-two percent had been in three or more facilities.

Table 21:
Facility Placement Per Youth

# Facilities	N	Percent
1	28	57%
2	11	22%
3	5	10%
4	2	4%
5	1	2%
6	2	4%
7	1	2%

Parental satisfaction with residential placement. Most parents (55%) expressed satisfaction with their child's residential placement. Interestingly, improvement in their child's condition did not affect their satisfaction with the residential placement. In 48% of the cases, no improvement was evident. However, 24% of the parents expressed satisfaction despite the lack of improvement. This suggests that parents may have been satisfied with residential placement because of the corroboration it afforded them of the severity of their child's need for residential services. It may also indicate that the respite provided by the residential placement supplied needed relief to a strained family system.

Table 22: Reported Parental Satisfaction

Status	N	Percent
Still In (Satisfaction level not yet determined)	10	20%
At Home Child Improved Parents Satisfied	15	31%
At Home Child Not Improved Parents Satisfied	12	24%
Not Satisfied	12	24%

Major reasons for placement.

Table 23: Reason for Placement

Reasons	Frequency
Aggressive behavior, angry, out-of-control, temper, violent, suicidal, homicidal	25
Runs away/skips school	6
ADHD/short attention span/hyperactive	6
Depression	5
Trouble with the law	4
Oppositional behavior	3
To help him/her with problems	3
Anti-social/social problems	3
ED	2
Acting out	2
Behavior problems	2
Medication management	2
Other: multi-handicapped, delusions, anxiety disorder, self-abusive, stealing, paranoia, non-compliant, self-esteem problems, failing grades	9

Major factors influencing placement. Far from being oblivious, parents knew of their children's needs and the sources of the problems, and were aware of the lack of services in the school and community.

Table 24: Factors Influencing Placement

Factors	Frequency
Lack of appropriate/affordable services at school and/or in the community	23
Family factors, including specific mention of the following: father deserted, divorce/separation, new brother, influence on sister, sibling rivalry, family dynamics, emotional abuse by stepfather, no friends/only child	13
Lack of financial security/insurance	3
Last ditch effort	2
Removal from sports	1
Other: needed 24-hour monitoring, medical problems, parents knowledge of psychology, dangerous	4

Services obtained from residential placement. Services obtained in residential placements paralleled the services reported offered by facilities responding to the residential facility study. However, the level or percentage of children obtaining services fell, on the average, approximately 40% below what facilities stated they provided to their clients.

Table 25: Reported Services Obtained

Services	N	Percent Youth Receiving/Rec'd	Percent Facilities Providing*
Individual therapy	36	73%	100%
Group therapy	25	57%	100%
Family therapy	24	49%	93%
Medication management	19	39%	98%
Parent support group	12	24%	
None	4	8%	
Recreational therapy	1		
12-Step Program	1		

*According to Task Force Residential Facility Study Data

Follow-up services, if any, after discharge.

Table 26: Reported Follow-Up Services

Service	Frequency	Percent
Individual therapy	22	45%
at additional charge	15	
no additional charge	6	
Family therapy	18	37%
at additional charge	15	
no additional charge	3	
Medication management	14	29%
Personal follow-up (phone, letter, or visit)	11	22%
Family or individual support group	11	22%
Referral to community resources	8	16%
Parent training	7	14%
Day treatment	4	8%

> *"If the many disturbed children of today are to survive and grow up to be functional happy adults, there have to be more options open and help available or society will pay dearly in later years when we have to deal with emotional cripples, overcrowded prisons, and drug abuse. These problems will be much greater that they already are."*
>
> Parent of 13-year-old boy with
> serious emotional disturbance

Mandate 4: Study Early Intervention and Prevention Strategies

One approach the Joint Task Force used to study prevention and early intervention services was to review research on probable causes of emotional disabilities. Serious emotional problems in children have been linked to a variety of early risk factors. Biological and physical factors such as genetic predispositions and abnormalities have been associated with later serious emotional and behavioral problems. Environmental factors such as early deprivation, institutionalism, physical and sexual abuse, poverty, poor parenting, and discipline practices have also been linked to serious emotional problems. Often these factors operate in concert, and the presence of many is directly linked to later development of serious emotional disturbance. (See Development of Emotional Problems in Children and Adolescents in Volume II.)

Additionally, the task force:

a. conducted a survey of school counselors' prevention strategies in schools; and

b. reviewed current school-based prevention initiatives in Texas, including the Student Assistance Program, Communities in Schools, Schools of Tomorrow, and the Texas Children's Mental Health Plan prevention package, to determine their statewide applicability.

The prevention and early intervention programs described in this section are targeted toward children who are at high risk for the development of emotional or behavioral disorders and their families. Biologically based disorders may not be prevented through programs of the type described below. Biologically based disorders require biologically based interventions. However, prevention and early intervention programs for children at high risk can, as research has demonstrated, be very effective in preventing the development of emotional or behavioral disabilities that do not originate from organic impairment.

School Counselor Prevention Strategies

To acquire baseline knowledge about current efforts in Texas public schools to prevent emotional disturbance, the Joint Task Force conducted a survey of public school counselors. (See Volume II for a complete report.)

The survey asked counselors what was being done in their schools to prevent emotional disturbance, what services they felt were needed, what services they felt were most effective, and what services they were providing to students already diagnosed as emotionally disturbed.

A wide distribution of responses was received, and included every region in the state except Region XIV. All sizes of schools were well represented. One hundred and forty-one responses were received.

The following constitute the major findings of the study:

Schools with no services. Smaller districts tend to have preventive services at the high school level only, with the exception of the smallest districts where there tend to be some preventive services.

Number of preventive services offered. The number of programs and strategies which a school reports using to prevent emotional problems is not related to the size of the district except for the smallest districts. The schools which appear to be doing the most to prevent emotional disturbance (as represented by number and kind of services reported) are those from the small districts (500-999 total students).

Variety and creativity of preventive services. Since there is no reason to suppose small- and medium-size districts in this state are more amply funded, this survey considers the number of strategies and programs that a school uses to prevent emotional disturbance as a measure of its commitment and creativity.

In this regard, size of the district bears an inverse-U shape relationship to the variety and amount of preventive programs offered. That is, the very small and very large districts have a negative relationship to creativity; the small- and medium-size districts have a positive relationship to creativity. Small- and mid-size school districts (500-999 and 1000-2999) clearly demonstrate more creativity in preventing emotional disturbance in its students.

Degree to which "counseling" is involved in prevention. In this survey, when "counseling" was reported as a strategy, it was assumed to be "traditional counseling," i.e., individual counseling or a form of counseling involving face-to-face therapeutic activity as it is commonly understood. As such, this survey found that as the size of the school district goes up, traditional counseling as a preventive activity tends to go down.

Special education services for students with emotional disturbances. Since special education services are mandated for students with emotional disturbance, one might suppose such services would be more highly reported than preventive services. This is not the case. Special education services tend to shadow preventive services in schools. The more preventive services, the more services for students diagnosed with emotional disturbance.

Need for preventive services. Perhaps surprisingly, the more preventive services a school reports, the more services it feels it needs. Schools doing the most to prevent emotional disturbance perceive the highest needs for services.

Professionally-intensive programs. Certain professional points of view appear related to the strategies used by the various sized districts. Smaller and mid-size districts tend to use approaches with more professional involvement, such as in-class guidance units and counseling. Large districts tend to depend upon crisis and peer-centered approaches. This appears related to the need to spread professional resources as far as possible.

Content of perceived needs. Across districts, at both the elementary and secondary levels, the primary need reported by counselors is for more time and more professionals to perform essential functions, i.e., counseling and psychological services. Other strongly reported needs were the services of a psychologist, and more parent training and parent groups. These needs do not vary by grade level.

Most effective strategies. The majority of respondents could not evaluate their services because, as was often stated, they felt everything they did was necessary -- and more. Therefore, the effectiveness of these services could not be evaluated.

Organization of interschool strategies. Most large district personnel knew little of prevention efforts being made at other schools in their district. This was especially true in high schools. This raises the issue of organization and continuity of prevention programs in schools across levels, an issue that, if addressed, could make prevention programs less hit or miss and more likely to function in a preventive way.

Additional comments. In an unrelated Texas Education Agency survey by the Task Force on Counseling and Social Work, 70% of 147 special education directors reported that no counseling services were available for students in special education; 97% of 295 participants at a conference on behavioral disorders reported negatively on the same issue; 61% of 76 elementary counselors reported likewise; and the ratio of special education counselors to special education students is 1:970.

Implications. The findings of the school counselor survey lead to the following discussion and implications. The data contained some surprises. Among these were the findings that relatively smaller and mid-size districts apparently make stronger and wider efforts to prevent emotional disturbance in children. (See Volume II for more discussion.)

The major implications that can be drawn from this study follow.

1. Every school district should be required to have a preventive plan in operation. This plan need not create a separate system but can be one which is incorporated into the school's at-risk program, counseling program, special education program, or 504 program in an articulated and traceable manner.

2. Efforts to consolidate schools, except very small schools, should take into account the effects of such consolidation on the pupils and staff. The results of this study are not encouraging for the prevention of mental health problems of students in very large systems.

3. A percentage of special education funds should be spent on preventive mental health as well as services to students diagnosed as emotionally disturbed.

4. The number of counselors in public schools should be increased and limits placed upon the time they spend on administrative and other school functions besides counseling activities.

5. The affective and social curriculum of school needs equal emphasis with the academic. Time and resources need to be dedicated to the emotional needs of students, as well as their academic needs.

School-Based Prevention Initiatives

The task force reviewed some creative approaches to preventing emotional and behavioral problems that are being developed in Texas. A few school-based programs offer promise. However, research on the effectiveness of these programs has not been completed.

There are several initiatives underway that are creative but not-so-new ways of delivering services to children and their families in Texas. They use the neighborhood school as the focus for delivering an array of services within the community. The school can be used either as the site for providing services (school-based services) or the school can make efficient and effective referrals to appropriate social service agencies (school-linked services). Either way, the goal is to use the school more effectively in helping children obtain "non-educational" services. The premise is that until these "non-educational" services (physical and mental health, recreation, etc.) are available at school, effective education will not be realized in many neighborhoods. The initiatives discussed below are examples of how this concept is being implemented in Texas.

Student Assistance Program: A Preventive Program for Youth At Risk for Emotional Disturbance. The Student Assistance Program focuses on comprehensive services delivered in a school setting. The services in the program include early identification, in-school support group intervention, and referral of high-risk students to community resources for assessment and treatment.

The Student Assistance Program operates on the premise that a student's school performance will be adversely affected by substance abuse or mental health problems. Originally focused on students at risk for alcohol and other drug related problems, the program model has been expanded to include students at risk for emotional and other mental health problems. The program can be used to help prevent and/or reduce substance abuse, teen pregnancy, suicide, truancy, dropping out, gang violence, child abuse, behavior problems, and other serious life issues.

Student Assistance Programs usually include support/educational groups. The regularly scheduled, small group, in-school counseling sessions offer support, education, and skills training to the participating students. They facilitate life skills development by providing a safe, supportive atmosphere in which students can learn and practice skills to cope more effectively with their problems. Support groups are made up of students who face similar problems, e.g., parental alcoholism, and provide a developmentally appropriate context within which to discover, examine, and experiment with change. Students often seek help from peers rather than adults when having troubles and can gravitate to dysfunctional groups such as gangs for security and acceptance. Support groups replace the dysfunctional peer association with functional problem-solving groups. The support groups offer students the chance to explore issues surrounding peer group pressure and decision-making.

There are some particular advantages in preventing or treating emotional disturbance in students through the Student Assistance Program model. Students from distressed and dysfunctional families can receive supportive services which strengthen their coping skills to prevent more serious psychopathology from developing. Counseling is available within the school setting. No fees, transportation, or waiting lists are required. Parental consent is requested but not necessary. Services are available without stigma or labeling the student as emotionally disturbed or mentally ill. The program is cost-effective because it can reach many students and has minimal overhead. The peer group support supplements adult assistance, and students often remain in touch after the groups to help each other in crisis situations.

Student Assistance Program models can be implemented by campus staff, by professionals hired by community agencies working within the school setting, or a combination of school and community professionals. A multiple-step Student Assistance Program process or system has proven effective and includes: early identification, initial action, preliminary assessment, referral to needed services, in-school support groups, monitoring, follow-up, and aftercare.

Training school district personnel is a vital element of successful Student Assistance Programs. The core team model suggests that training involve experiential, team building, and personal growth exercises as well as relevant didactic experiences. Training focuses on identifying specific behaviors that may indicate student distress or disturbance. Staff do not diagnose disorders, but rather refer students and their families to appropriate agencies and professionals or to support groups within the school for assessment and treatment when necessary.

Most successful programs include an evaluation component to demonstrate effectiveness to gain continued financial support and also to promote long-range planning. While comprehensive evaluations of Student Assistance Programs are not commonplace, existing findings are favorable. Studies show that programs which include support groups have had positive effects such as improved grades or test scores, improved attendance, decreased disciplinary action, and decreased dropout rates. Students report an increase in self-esteem and coping skills as well as decreased use of alcohol and drugs. Other elements identified as effective in Student Assistance Programs include ongoing staff development and inservice, mental health or affective education curriculum, peer assistance or leadership programs, and increased parent involvement.

While Student Assistance Programs are based in regular education, they are both supplemental and reinforcing to special education. Different goals underlie each program. Student Assistance Programs identify students at risk for emotional disturbance and other mental health difficulties and seek to prevent or ameliorate these conditions. Special education departments provide for the individual educational needs of students with handicaps, including those with emotional disturbance. In theory, effective Student Assistance Programs may reduce the number of students who are emotionally disturbed. Special education students can benefit from Student Assistance Program services and often participate in on-campus support groups with successful outcomes.

Student assistance programs are operating in several Texas school districts including Austin, Cypress-Fairbanks, and Humble.

Communities in Schools. Started initially as a dropout prevention program for high school students in disadvantaged areas in the 1960s, Communities in Schools (CIS) was introduced to Texas in Houston and by 1985 had expanded to four other cities. The overall program objective is to provide campus-level intervention/prevention services for at-risk students. The services focus on seven areas: counseling, remedial instruction, social service referral, pre-employment skills, training, enrichment activities, and parental involvement.

The major objectives of CIS are to: (1) improve school performance, (2) improve self-esteem, (3) encourage parental involvement, (4) reduce disruptive classroom behavior and referrals to the juvenile justice system, and (5) improve academic achievement. The CIS state office is funded with federal Junior Training Partnership Act funds through an interagency contract between the Texas Department of Commerce and the Texas Employment Commission. In 1987, CIS was legislated into the Texas Employment Commission. It is projected that by the 1990-91 school year, CIS services will be available on 89 campuses in 16 cities in Texas. The plan is to serve over 15,000 students a year by that time.

Schools of Tomorrow. An initiative that is in the early stages of implementation is the Schools of Tomorrow project developed by the Hogg Foundation for Mental Health. Four cities in Texas have been awarded grants to undertake this project in one middle school and one or two of their "feeder" elementary schools. The concept and goals of this initiative are similar in many ways to those of Communities in Schools.

Grants awarded by the Hogg Foundation are used to hire "project coordinators." The coordinators' primary responsibilities include working with each community to determine the services that a particular neighborhood needs and bringing in those services as prioritized by the principal, counselors, teachers, and parents. In all cases except one, the coordinator is an employee of the school district. In Houston, the coordinator is an employee of the Family Service Center.

The coordinators work with social service agencies to establish linkages between these agencies, individuals in the neighborhood, and the school. The long-range plan is to institutionalize these services within the school. School ownership of the project and the services offered is a major goal.

The services offered through Schools of Tomorrow vary by site; each community has its own priorities and immediate needs. A rigorous evaluation component is included in the project design so that, ultimately, this project can be replicated in other schools in Texas. The attempt will be to demonstrate the efficacy of Schools of Tomorrow in terms of both economic and social outcomes.

Texas Children's Mental Health Plan. The Texas Children's Mental Health Plan proposes three packages of services for children with serious emotional disturbances. Package Two provides for preventive school-based services in concert with mental health, physical health, and human service agencies. This program proposes that mental health, drug abuse, health, and human services be coordinated within a central location--the elementary school. By placing agency personnel in schools, effective linkages to community services can be made, and supportive services to children at risk of developing emotional problems and their families can be provided. Additional information is available from the Mental Health Association of Texas.

Early Childhood Intervention

One of the most successful interagency efforts within Texas is the Early Childhood Interventon (ECI) program. The Texas Education Agency, Texas Department of Mental Health and Mental Retardation, Texas Department of Human Services, and Texas Department of Health provide staff and services to help families and young children with physical handicaps and developmental disabilities. ECI provides both home- and school-based programs as well as case management. These programs have been successful in providing early intervention to help the child make a smooth transition into public education.

At present, funding limitations restrict the enrollment of infants and young children at risk for emotional disturbance. This includes children born to families with a history of mental illness, mental retardation, and substance abuse. Children with histories of early abuse and neglect are excluded, unless they exhibit developmental delays in three areas. Very often the signs of emotional problems in infants and toddlers go unnoticed.

Currently, some states, including North Carolina, Vermont, and Oregon, are attempting to broaden their eligibility criteria for infants with special needs and to use Early Periodic Screening Diagnosis and Treatment to screen this population and increase services to them.

These initiatives illustrate the coordination between schools and social service providers in Texas. They are exciting new attempts by agencies and individuals to offer services where children spend the largest part of their day. These programs are pieces of the puzzle that many communities are trying to put together to form an efficient and effective school-based continuum of care for children in Texas.

> *"This is the DFW area, so there is a wide array of expensive outpatient services. There are almost none for families without insurance. Two United Way agencies provide counseling, but have long waiting lists."*
>
> Special Education Director

FUNDING STRATEGIES

Financing Strategies for Children's Mental Health Services in Texas

A recent survey by the National Alliance for the Mentally Ill ranked Texas 49th in per capita spending in mental health services. This funding crisis is even more severe in light of children's services, which continue to receive less priority than adults'. The expansion of children's services has been limited within the Texas Department of Mental Health and Mental Retardation due to a law suit which required that new dollars be targeted to services for adults.

Several innovative strategies have been identified which have successfully reduced the funding deficits in children's mental health services. These include phasing down institutions, blending interagency budgets, expanding medicaid, providing fiscal incentives between state and local entities, expanding private insurance, trust funds, and marking revenue. Texas is beginning to use several of these strategies to expand children's mental health services. They are as follows.

Blending Interagency Budgets/Pooling Resources

The model used in Ohio, Tennessee, Virginia, and Iowa blends state and federal resources from all child-serving agencies into a single budget. The funds are then targeted for services for children with serious emotional disturbance. The approach exemplifies these states' "shared responsibility" for children, as well as a highly developed level of interagency coordination. There are three initiatives in Texas which incorporate this concept.

- The first involves the blending of funds from the Texas Department of Mental Health and Mental Retardation and the Texas Department of Juvenile Probation to develop a model program for treating youth with emotional disturbance who are part of the juvenile justice system. The program, located in Temple, combines staff from Central Counties MHMR Center and juvenile probation workers from a nine-county area. Assessment, case management, and family preservation services are provided.

- The second effort involves interagency collaboration in planning and service development. The funding vehicle is a coordinated legislative budget request. Participating agencies identify dollars that will be blended for specific programs for children with serious emotional disturbance. The Mental Health Association of Texas' Children's Mental Health Plan includes a legislative budget request from the Texas Department of Mental Health and Mental Retardation, Texas Commission on Alcohol and Drug Abuse, Texas

Education Agency, Texas Department of Human Services, Texas Department of Health, Texas Rehabilitation Commission, Texas Juvenile Probation Commission, and Texas Youth Commission. The request is for three service packages which include prevention and essential community-based services to reduce out-of-home placement.

- The third effort is a legislative mandate for coordinated transition services for all youth with disabilities. The participating agencies are the Texas Commission for the Blind, Texas Employment Commission, Texas Education Agency, Texas Rehabilitation Commission, Texas Department of Human Services, and Texas Department of Mental Health and Mental Retardation. Transitional service plans, and vocational, mental health, and other community support services will be provided for all students 16 years and older who have handicaps, including emotional disturbance. These services will only be possible through a significant increase in the appropriations to all the participating agencies.

Expanded Medicaid

The Texas Department of Mental Health and Mental Retardation and the Texas Department of Human Services are currently expanding the state's medicaid plan to include targeted case management and related mental health services. The proposed rehabilitation option will allow reimbursement for day treatment, in-home services, outpatient therapy assessment, and crisis stabilization. The use of Early and Periodic Screening Diagnoses and Treatment Services will also be available to medicaid eligible children 0-18. The Omnibus Budget Reconciliation Act 1989 Amendment required this program to provide coverage for treatment of current mental/emotional problems. The key to the success of this initiative will be the addition of specific assessment items or screening which will effectively identify children with emotional problems. These medicaid efforts should be completed by 1991. Currently, the Texas Education Agency is exploring the special education system option to bill medicaid for health related services. This option could add some incentive for school districts to identify and serve children with emotional disturbance.

In-Home and Family Support Funds

During the 70th legislative session, House Bill 1154 was passed. It created the Texas Department of Mental Health and Mental Retardation In-Home and Family Support Program which enables persons with mental or developmental disabilities to purchase services that support them in their home community.

During 1988, the Texas Department of Mental Health and Mental Retardation allocated $2 million for the program and $4 million for 1989. The initial funding was available only to 19 mental health and mental retardation authorities.

The program provides up to $3,600 per client and an additional one-time grant for architectural modifications or equipment. These funds can be used by children and adults. However, during the first year of the program, very few children used it. The following services can be provided through the program: health services, counseling or training programs, home care, respite care, transportation services, and room and board for evaluation/treatment.

Other Programs

Another program which funds family support is the Texas Education Agency Non-Educational Community-Based Services Program. Two million dollars was made available by the 71st Texas Legislature to be used to help children with emotional disturbance, autism, and mental retardation who are at risk of residential placement. This program functions as a collaborative effort between the Texas Education Agency and Texas Department of Mental Health and Mental Retardation. A school district must initiate the process and develop a service plan in conjunction with the mental health authority. The mental health authority is given the first option to use the money to provide or develop the service for the child and family. This component is intended to serve as an incentive to increase public mental health services within the community. Case management, respite care, family preservation, and behavior management training are a few of the support services provided through this program. Many school districts have hesitated to use these funds because it is "soft money" and may end at the close of this biennium.

Clearly, Texas is embarking on new initiatives that will increase mental health services to children. The Texas Department of Mental Health and Mental Retardation's $2 million line item for children's community mental health services is the department's first dedicated appropriation for youth. The majority of the other efforts, though exciting, are also dependent on an increase in legislative appropriations. During this time of fiscal conservatism in our state, we must continue to take a critical look at current spending methods. Areas to consider are the reappropriation of current dollars spent on residential care including state hospitals, blending or pooling some portion of existing budgets from child-serving agencies responsible for youth with serious emotional disturbance, and continued emphasis on expanding private insurance to increase coverage for community-based services.

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What Innovative Strategies Are Available to Finance Child Mental Health Services?

Faced with increasing demand and decreasing funds for mental health services, states are looking for creative ways to stretch their dollars and use funds more efficiently. Following are some innovative state funding strategies.

Phasing down institutions. Several states, including Florida, New Jersey, Ohio, and Vermont, have undertaken projects to close state child and adolescent inpatient units and shift the savings to develop community-based services for this population. Colorado, Louisiana, Pennsylvania, and Texas also have initiated projects to reduce acute hospital capacity, but it is uncertain whether these initiatives will benefit child and adolescent services directly. Some states, such as Iowa, also have closed down juvenile institutions and diverted savings to create noninstitutional alternatives. A portion of these funds was used to provide intensive home-based services.

Blending interagency budgets. Nebraska, Ohio, Tennessee, Virginia, and pilot projects in Iowa are combining funds from both federal and state sources to increase the availability and appropriateness of services. These states are blending resources dedicated to children within state mental health, education, juvenile justice, and child welfare agencies into a single budget. The pilot projects in Iowa will be evaluated to determine whether the flexible financing system results in more cost-effective delivery of services. Also, alternative reimbursement systems will be developed to tie outcome measures to the finance system. These initiatives are discussed in further detail in Question Seven.

Expanding Medicaid initiatives. Many children who are emotionally disturbed can receive Medicaid since virtually all children in foster care placements automatically are eligible. Some children qualify for Medicaid benefits through the federal Supplemental Security Income and the Aid to Families with Dependent Children programs. The Medicaid program provides an opportunity for states to receive federal funds because the federal government pays at least 50 percent of each state's Medicaid services. To the extent that the state Medicaid plan covers mental health services, the state benefits since providing mental health care to its citizens is primarily the state's fiscal responsibility. Examples of strategies that states can use in their Medicaid programs include:

- *Expand home- and community-based services.* Services can be expanded under existing optional provisions where no waiver is required and involve rehabilitation, personal care, and clinic services, such as off-site home- or school-based clinic services. Sixteen states cover day treatment or partial hospitalization in inpatient facilities, and 26 states dispense these services in community mental health centers or clinics. Home-based services are covered in Kentucky, Maine, North Carolina, Ohio, and Washington. Maine, Michigan, Ohio, North Carolina, Washington, and Wisconsin allow intensive crisis counseling or emergency services. Mental health and medical care services are provided in residential treatment centers in Maine and New York, and Michigan includes assistance in daily activities and self-administered medication components under the personal care option. Recent federal Medicaid changes make it clear that services required under Individualized Education Plans pursuant to P.L. 94-142 also can be covered, including mental health services.

- *Seek waivers through the Medicaid Home- and Community-Based Services Program.* This waiver allows Medicaid dollars to be used, under some circumstances, to provide a broad range of home and community services to persons who otherwise would require care in an institutional setting. Despite the success of this program, Vermont is the only state that has an operational waiver for children who are emotionally disturbed.

- *Implement optional case management services.* Georgia, North Carolina, Pennsylvania, West Virginia, and Wisconsin have implemented a case management service that can assist children who are emotionally disturbed. In addition, three states have submitted plans to the Health Care Financing Administration, and at least six other states plan to pursue this available option.

- *Increase community mental health center reimbursement rates to leverage federal funds better.* States, particularly those with a high federal matching rate, can benefit by leveraging resources from the federal government in a better manner. Rather than relying on 100 percent state or local funds to subsidize operating deficits of community mental health centers, states can use the federal matching portion to expand services with no increase in state expenditures. If a state is now paying for 100 percent of a service, such as outpatient care, under this provision the federal government will pick up these costs up to the federal matching rate. For example, if Alabama paid for outpatient services with 100 percent state or local funds and its 1990 Medicaid matching rate is 73 percent, it is possible that the costs for these services will be only 27 percent rather than 100 percent.

- *Use mental health authority resources as state matching funds.* Although the fiscal resources used to expand Medicaid coverage historically come from the Medicaid agency's budget, the mental health authority's existing resources may be an appropriate and feasible source to make expansions. Maine increased reimbursement rates to community mental health centers in 1985 by 87 percent with both state and federal dollars. The state matching funds came from mental health authority resources. This strategy could be used for other types of service expansion options.

- *Cover inpatient services for individuals under age 21.* States have the option of providing Medicaid coverage for inpatient psychiatric hospital services for eligible individuals under age 21 at either freestanding facilities or state institutions. If states choose to use this option, they are able to leverage significant amounts of federal money, since they historically have been responsible for 100 percent of care costs for persons under age 21. The number of states that have opted for this coverage has increased from 22 in 1984 to 34 in 1987. The major deterrent of this financing strategy is that it is likely to stimulate increased demand for inpatient services. States using this option may want to consider developing strong utilization review and preadmission screening policies, as well as regulating the number of hospital beds that are created for children who are emotionally disturbed.

- *Adopt the special education system option to bill for health-related services.* In 1988, states were given the option to have Medicaid provide reimbursement for psychological and other health-related services, such as speech, occupational, and physical therapy provided to emotionally disturbed and other handicapped students by special education programs. Previously, the overall responsibility for providing these health-related services was up to each school district, thus offering an incentive to underidentify and underserve emotionally disturbed and other handicapped students. With this barrier removed, schools may play a larger role in helping meet the needs of emotionally disturbed and other handicapped children by using Medicaid funds as a new reimbursement source. While a number of states are considering this option, none has implemented it to date.

- *Use the early and periodic screening, diagnosis, and treatment services.* Through their EPSDT programs, states may offer additional services to Medicaid-eligible children, ages 0-18, without having to offer similar benefits to other Medicaid recipients. Congress strengthened this provision in 1989 by requiring that states provide coverage for treatment to correct mental or physical problems identified by EPSDT health screenings performed by physicians, even if these follow-up services are not covered under the state's Medicaid plan. This new provision enables states to cover a broad range of mental health services for children who are emotionally disturbed.

Developing fiscal incentives between state and local entities. Minnesota, Ohio, and Wisconsin have established single points of fiscal and program authority for both hospital and community funds used to provide services to adults and children with mental illness. These states generally allow county boards to develop and administer a range of community services. Ohio, whose system focuses on children, and Wisconsin may channel dollars saved through the reduction of state hospital usage to develop and fund community-based services. Some states have developed cost-sharing arrangements with local authorities for increases in state hospitalization usage beyond a targeted amount. The California Legislature passed a law that requires counties to pay for 10 percent of state hospital costs and 100 percent of the costs beyond a county's allocated inpatient days for children.

Expanding private insurance. States can utilize several strategies to expand the range of services available to privately insured children. Some states or communities have negotiated with private insurers to increase the range of services covered on a demonstration basis. Others have broadened coverage for community services. Prudential Insurance Company of America, the largest insurer in the country, has expanded its hospital coverage policies to include partial hospitalization or day treatment. Capitation-type arrangements have been developed between community providers and insurers that allow the delivery of a much broader range of services in anticipation that the utilization rate of inpatient resources will decrease. Twenty states also mandate coverage of mental health services, and seven require private insurers to offer the option of mental health coverage.

Developing a third-party billing plan. Recent federal legislation clarifies that Medicaid can be used to fund related services under a child's Individualized Education Program. Several states, including Connecticut and Utah, have developed a third-party billing plan to ensure that the education department recovers some of the cost of supplying "related health services" to handicapped children who have health insurance or who are Medicaid eligible. Insurers are billed for services from approved providers with parental permission. The plan is complex, but a 1987 General Accounting Office report indicated that the Connecticut plan has the potential of returning $5-$6 million in Medicaid payments alone. For 1988-89, $550,000 was returned to Connecticut in Medicaid reimbursement. Of that amount, $500,000 was from one of six districts in which the plan was piloted. However, there are concerns with the plan—if the insured party is denied coverage, coverage is reduced, or rates are increased because of third-party billing, the education department could be held liable.

Establishing trust funds. The Self-Sufficiency Trust (SST) evolved from research by the National Foundation for the Handicapped. SST provides a mechanism for the families of children with handicaps to contribute money to their children without jeopardizing the recipient's eligibility for public programs. Income from the trust can be used to enhance, supplement, and enlarge services to all disabled residents receiving care from state-supported programs. Illinois was the first state to establish an SST in 1986, and Maine, Montana, and Oregon recently enacted SST legislation. Alaska, Florida, Hawaii, Massachusetts, Michigan, New York, and Virginia are considering proposals to create these trusts within their own states.[74]

Earmarking revenues. Earmarking, the practice of designating specific taxes and fees for particular programs, is receiving widespread national interest. Proponents claim that earmarking increases total state revenues, ensures a minimum level of funding for recipient programs, contributes to the stability of a state's financial system, and guarantees continuity for specific programs. Opponents of the practice caution that it may cause a reduction in the contribution that a program has been receiving from general fund monies—this may result in an actual decrease in funding from previous levels. In addition, critics warn that earmarking may result in unfair allocation of funds, and the traditional sources of earmarked funds produce relatively slow-growing revenues. Approximately one-half of the states designate state tax revenue for mental health and substance abuse services.[75] California, for example, allocates earnings from the sale of properties confiscated in substance abuse cases for a Primary Prevention Trust Fund. These monies are used to initiate collaboration or early intervention mental health and education programs in the school.

Providing family support dollars. Many families choose to provide care at home to a child who is emotionally disturbed. Cash assistance programs provide dollar resources directly to families, who in turn select and pay for needed services. Iowa has a small family support project for families with children who are developmentally or emotionally disabled. The project provides $260 per month to families for a variety of services such as respite care, food, clothing, and specialized treatment.[76]

Reusing surplus state hospital property. Although the number of public mental hospital patients has declined by almost 80 percent in the last 25 years, only 16 of the 274 state psychiatric hospitals have closed. This leaves many state psychiatric hospitals with empty buildings and surplus land that could be a source of funds or benefits for persons with mental illness. Potential exists to sell, rent, or lease empty buildings to new users or to lease land to private residential developers in exchange for a specified number of housing units or other benefits.

In recent years, there has been significant legislative activity relating to the reuse of state hospital property. Illinois established the Mental Health Trust Fund in July 1988, which earmarks revenues obtained from state hospital property leases for use by the Department of Mental Health. California authorized the lease of state hospital land, with income allocated to the Patient Benefits Fund to aid patients in five of the state hospitals. New York approved the lease of state hospital property to a housing facility and an alcoholism treatment program in 1988.[77]

NEXT STEPS

The Joint Task Force recommendations represent a new beginning in providing services for children and youth with emotional disturbance and their families. They incorporate intervention approaches which are family-centered, developmentally appropriate, culturally sensitive, and provided in the least restrictive environment.

Essential to improving the service delivery system is a shared responsibility among the major child-serving agencies in planning and implementing services for children with severe emotional disturbance. Cooperative efforts now include, and must continue to include, all major agencies that serve children. To be effective, however, these state-level collaborative efforts must be implemented locally.

This report underscores the need for a major restructuring of services to children. The restructuring as described in this report will create a more balanced system of public care for Texas children now and in future generations. As planners, advocates, and legislators develop a children's mental health system, the following key points should be in the foreground.

. Family Involvement. To date, parents of children with severe emotional disturbance have not been equal partners in the planning and delivery of services. The parent survey report confirms that many parents know what kind of services their children need. It further indicates their desire for opportunities to collaborate with professionals.

. Advocacy. Established advocacy groups such as the Mental Health Association; Texas Alliance for the Mentally Ill; Advocacy, Incorporated; and professional organizations must help increase public awareness about children's mental health needs and support current planning and service expansion efforts.

. Balanced System of Care. Survey data and research indicate that a complete array of services must be available to help reduce inappropriate residential or out-of-home placement of children, and to provide aftercare services to children who are returning from residential placement.

. Evaluation of Services. The Joint Task Force report clearly indicates over-reliance on residential treatment for the care of children with serious emotional disturbance, and the large portion of state dollars that support these placements. Rigorous analysis must be conducted to assess the utility of these expenditures in relation to their outcome. Cost savings alone can not be the driving force behind system change. There may be some services that are more expensive to provide at the community level. However, if more successful outcomes emerge, then the money will have been well spent. Future service expansion efforts must have a strong evaluation component to help the state develop and fund only those programs that offer the most benefit.

. School- and Home-Based Services. The report articulates a clear need for community-based services with particular emphasis on school- and home-based components. The emphasis on school-based services includes programs which provide related services to children who are identified as seriously emotionally disturbed and early intervention programs for those children at risk. Home-based services are effective in mediating acute psychiatric crises and as part of ongoing family support. Out-of-home placements have been reduced and students retained in full-day programs when there is a strong working relationship between school personnel and mental health center staff.

. Training and Reassigning Current Professionals. There is a serious deficit of both mental health and school personnel who are adequately trained to serve the target population. There is also a serious shortage of professionals in mental health centers to provide even minimal services. Intensive, statewide, multi-agency training and hiring of children's mental health professionals must begin.

. Legislative Support. Focused funds are needed to redress the current imbalanced system. Numerous legislative mandates have created the climate for interagency coordination. The true impact of these efforts will not be realized without financial support. Increasing medical service capacity through medicaid expansion is one option along with funding coordinated planning efforts such as the Texas Children's Mental Health Plan.

The Joint Task Force is aware that these recommendations are made during a time of severe fiscal restraint. However, it is imperative that corrective action begin. As a state, we cannot afford to leave the current imbalanced system alone. We cannot afford the effects upon our children. We must act.

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APPENDIX

DEFINITIONS OF EMOTIONAL DISTURBANCE

Interagency Children's Mental Health Initiative: Target Population Definition For Children With Serious Emotional Disturbance

MUST HAVE (I, II, & III) OR (I, II, & IV) OR V:

I. DIAGNOSIS

DSM-III R Axis I or II diagnosis, except a single diagnosis of psychoactive substance use disorder, developmental disorder, or V code. Organic mental disorders are included only while behaviors are a danger to self or others.

II. RISK OF OR SEPARATION FROM FAMILY

Risk of or separation from family due to, for example:

(1) chronic family dysfunction involving a mentally ill and/or inadequate caretaker, or multiple agency contact, or changes in custodial adult; or

(2) going to, residing in, returning from any out-of-home placement, e.g., psychiatric hospital, short-term inpatient, residential treatment, group or foster home, corrections facility, etc.

III. FUNCTIONAL IMPAIRMENTS/SYMPTOMS

Must have A or B:

A. Functional Impairment. Must have substantial impairment in two of the following capacities to function (corresponding to expected developmental level):

1. Autonomous functioning.
2. Functioning in the community.
3. Functioning in the family or family equivalent.
4. Functioning in school/work.

B. Symptoms. Must have one of the following:

1. Psychotic symptoms.
2. Suicidal risk.
3. Violence. At risk of causing injury to person or significant damage to property, due to mental illness.

IV. HISTORY

Without treatment, there is imminent risk of decompensation or separation from family in Section II above.

V. SPECIAL EDUCATION STUDENTS

Special education students who have been assessed as being seriously emotionally disturbed and have identified mental health needs in their individualized education'plans.

Current Educational Definition of Emotional Disturbance

The Joint Texas Education Agency/Texas Department of Mental Health and Mental Retardation Task Force on Emotional Disturbance publication, Guidelines for Assessment of Emotional Disturbance, describes assessment issues in determining emotional disturbance for special education purposes. These guidelines follow the Public Law 94-142 federal definition of emotional disturbance which reads:

> "The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:
>
> (1) an inability to learn which cannot be explained by intellectual, sensory or health factors;
>
> (2) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
>
> (3) inappropriate types of behavior or feelings under normal circumstances;
>
> (4) a general pervasive mood of unhappiness or depression; or
>
> (5) a tendency to develop physical symptoms or fears associated with personal or school problems.
>
> The term includes children who are schizophrenic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed."

Current Mental Health Definition of Emotional Disturbance

The Texas Department of Mental Health and Mental Retardations definition of emotional disturbance that is proposed for adoption, differs from Texas Education Agency's definition and reads as follows:

> "Children and adolescents with serious mental illness are those individuals under 18 years of age who, because of psychosis or other emotional and/or behavioral disorders, suffer from severe disability which requires

> sustained treatment interventions for a year or more and which requires attention from two or more agencies."

In addition, the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM III-R) includes the clarification and definition of numerous mental disorders. A mental disorder is defined as a:

> "...clinically significant behavioral or psychological syndrome or pattern...that is associated with present distress (a painful symptom) or disability (impairment in one or more areas of functioning) or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom." (p. xxii)

The syndrome or pattern must be viewed as an expression of a dysfunction in the person.

The relationship between the DSM III-R classification system and educational definition under P.L. 94-142 is discussed in an earlier task force report (June 1988).

COMPLIANCE STATEMENT

TITLE VI, CIVIL RIGHTS ACT OF 1964; THE MODIFIED COURT ORDER, CIVIL ACTION 5281, FEDERAL DISTRICT COURT, EASTERN DISTRICT OF TEXAS, TYLER DIVISION

Reviews of local education agencies pertaining to compliance with Title VI Civil Rights Act of 1964 and with specific requirements of the Modified Court Order, Civil Action No. 5281, Federal District Court, Eastern District of Texas, Tyler Division are conducted periodically by staff representatives of the Texas Education Agency. These reviews cover at least the following policies and practices:

(1) acceptance policies on student transfers from other school districts;

(2) operation of school bus routes or runs on a non-segregated basis;

(3) nondiscrimination in extracurricular activities and the use of school facilities;

(4) nondiscriminatory practices in the hiring, assigning, promoting, paying, demoting, reassigning, or dismissing of faculty and staff members who work with children;

(5) enrollment and assignment of students without discrimination on the basis of race, color, or national origin;

(6) nondiscriminatory practices relating to the use of a student's first language; and

(7) evidence of published procedures for hearing complaints and grievances.

In addition to conducting reviews, the Texas Education Agency staff representatives check complaints of discrimination made by a citizen or citizens residing in a school district where it is alleged discriminatory practices have occurred or are occurring.

Where a violation of Title VI of the Civil Rights Act is found, the findings are reported to the Office for Civil Rights, U.S. Department of Education.

If there is a direct violation of the Court Order in Civil Action No. 5281 that cannot be cleared through negotiation, the sanctions required by the Court Order are applied.

TITLE VII, CIVIL RIGHTS ACT OF 1964; EXECUTIVE ORDERS 11246 AND 11375; TITLE IX, 1973 EDUCATION AMENDMENTS; REHABILITATION ACT OF 1973 AS AMENDED; 1974 AMENDMENTS TO THE WAGE-HOUR LAW EXPANDING THE AGE DISCRIMINATION IN EMPLOYMENT ACT OF 1967; AND VIETNAM ERA VETERANS READJUSTMENT ASSISTANCE ACT OF 1972 AS AMENDED IN 1974.

It is the policy of the Texas Education Agency to comply fully with the nondiscrimination provisions of all federal and state laws and regulations by assuring that no person shall be excluded from consideration for recruitment, selection, appointment, training, promotion, retention, or any other personnel action, or be denied any benefits or participation in any programs or activities which it operates on the grounds of race, religion, color, national origin, sex, handicap, age, or veteran status (except where age, sex, or handicap constitute a bona fide occupational qualification necessary to proper and efficient administration). The Texas Education Agency makes positive efforts to employ and advance in employment all protected groups.

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Education and Mental Health:

Profitable Conjunction

Volume II

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EDUCATION AND MENTAL HEALTH: PROFITABLE CONJUNCTION
VOLUME II

Report of the Joint Texas Education Agency/
Texas Department of Mental Health and Mental
Retardation Task Force on Emotional Disturbance

Submitted to the Governor, Lieutenant Governor,
And the Seventy-Second Texas Legislature

1989-1990

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Texas Education Agency
1701 North Congress Avenue
Austin, Texas 78701-1494

State Board Of Education
1701 North Congress Avenue
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(512) 463-9007

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Esteban Sosa
San Antonio, District 3

W.N. Kirby, Ph.D.
Commissioner of Education
(512) 463-8985

January 1991

The Honorable Ann W. Richards, Governor of Texas
The Honorable Bob Bullock, Lieutenant Governor of Texas
The Honorable Gibson D. Lewis, Speaker of the House
Members of the 72nd Legislature

Section 1.11 of the Texas Education Code required the Texas Education Agency to continue the Joint Texas Education Agency/Texas Department of Mental Health and Mental Retardation Task Force on Emotional Disturbance. The task force was mandated to conduct a study to evaluate and make recommendations concerning residential costs, the creations of community-based services, family involvement, and early intervention and prevention strategies specific to children and youth with emotional disturbance.

This report contains recommendations for restructuring mental health services to children and youth. The Joint Task Force on Emotional Disturbance believes that the restructuring as described in this report will result in more cost-effective services to children and youth.

I hope you will find this information useful as you continue to address mental health issues pertaining to children and youth with emotional disturbance.

Respectfully submitted,

Carolyn Crawford

Carolyn Honea Crawford, Chairman
State Board of Education

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JOINT TEXAS EDUCATION AGENCY/TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION TASK FORCE ON EMOTIONAL DISTURBANCE

Jo Ann Mitchell Burns, Ed.D.
Pan American University

Clint Capers, M.Ed.
Waco Center for Youth

Cheri Crane, M.Ed.
Crane/Reynolds, Inc.

Grace England, Ph.D.
Klein Independent School District

Sara Gonzales
Texas Alliance for the Mentally Ill

Ruth Haak, Ph.D.
Balcones Coop, Austin

Regenia Hicks, Ph.D.
Texas Department of Mental Health and Mental Retardation

Karen Jackson, Ph.D.
Texas Woman's University

Scott Keir, Ph.D.
Hogg Foundation for Mental Health

Betty Phillips, Ph.D.
Austin Independent School District

Ruth Turner, Ed.D.
Dallas Independent School District

Beverly Sutton, M.D.
Austin State Hospital

Jo Webber, Ph.D.
Southwest Texas State University

Kimberly Hoagwood, Ph.D.
Chair, Joint Task Force
Texas Education Agency

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TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
INPATIENT FACILITY STUDY

The purpose of this section is to explore trends in inpatient care offered by the Texas Department of Mental Health and Mental Retardation (TDMHMR) over the past three years. Data on the six state hospitals that have units for children and adolescents[1] and Waco Center for Youth were collected and analyzed. Some general demographic trends will be discussed initially followed by an analysis of the cost of care for these youths.

It should be noted that these data are from state hospitals which are the most restrictive alternative for children and adolescents in Texas. Number of youths served, beddays accumulated, and overall costs were calculated for the task force by staff at TDMHMR.[2] These data were generated for persons age 0 to 18 with a mental health diagnosis in the children and adolescents units of the seven institutions for fiscal years 1987, 1988, and 1989.[3]

The task force focused only on this most restrictive alternative for three basic reasons. First, the cost of taking care of this population is paid for by the state of Texas and therefore, affects all the "pocketbooks" of the residents of Texas. The task force decided to study inpatient care with particular emphasis on the cost to Texans. Second, this is most likely the least expensive inpatient treatment available in the state. If it can be demonstrated that large amounts of money are being spent in these public institutions, it should become apparent that even greater amounts are being spent annually for private care. Third, the task force realized that it was not going to be possible to get data that were as specific, accurate, and reliable as the TDMHMR Client and Registration (CARE) System data. These were the only data that the task force would be able to collect that would allow for a reliable analysis of inpatient treatment for children and adolescents.

Finally, it should be noted that of the 12 state hospitals and centers, eight have specific units for children and/or adolescents. Only four have both children and adolescent units. This severely limits the number of places to which an individual or agency can refer a child requiring inpatient care. It also means that in many cases a youth will have to be situated a long distance from home when they are admitted into a child or adolescent unit.

Demographic Trends

There has been a consistent increase in the number of children and adolescents served in the state hospitals studied over the past three years. (See Table I) In fact, the increase has been over 18% since fiscal year 1987. Each year there has been approximately twice as many males served as females.

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[1] Austin, Big Spring, San Antonio, Terrell, Vernon, and Wichita Falls State Hospitals.

[2] Management Analysis and Research Unit, TDMHMR, 1990.

[3] The fiscal year begins on September 1 and ends on August 31.

The overwhelming majority of clients served have been white. White children and adolescents comprise over 60% of the state hospital population for this age group. Hispanic youths are represented twice as much as Black youths but are still underrepresented in comparison to their proportion in the total population of Texas.

The age group that is most often found in the state hospitals is the 16 to 18 year age category. (See Tables and Figures IIa-IIc.) However, the group aged 12 to 15 is close behind. Less than 1% are under the age of six. Nonetheless, there are still a few of these cases, almost all of them males.

Vernon State Hospital admitted the largest number of children and adolescents (621 individuals) of all those explored in this analysis. Vernon is followed by San Antonio (297), Austin (311), Wichita Falls (263), Terrell (213), and Big Spring (118). Waco Center for Youth served 243 children and adolescents for fiscal year 1989. Among the three largest providers for this age group, Vernon and Austin served mostly white youths while San Antonio's majority of children and adolescent admissions were Hispanic. These are the only conspicuous differences between these hospitals in the populations they serve.

Bedday Totals

Vernon State Hospital had by far the largest number of beddays accumulated in their adolescent units in comparison to the other state hospitals. (See Table III.) It is important to note, however, that there has been a decrease in the bedday totals for the past three years. There has been a reduction of almost 1500 beddays since fiscal year 1987. This has occurred at the same time there was a gradual increase in the number of children and adolescents served by state hospitals overall. The total bedday count for all hospitals, fiscal year 1987 to fiscal year 1988, saw an increase in bedday totals (1700 more beddays) while there was a decrease of beddays from fiscal year 1988 to fiscal year 1989 (2335 fewer beddays).

Waco Center for Youth had the second largest accumulation of beddays for this population of all the facilities studied here. The trend of beddays for this institution echoed the pattern for the overall group of state hospital beddays. They experienced an increase from 1987 to 1988 but then experienced a decrease from 1988 to 1989. The number of beddays Waco Center for Youth accumulated in 1989 is back down to the total number of beddays for 1987.

Cost Data

The average cost per day for each of the institutions ranged from under $155 per day (Vernon State Hospital[4]) to over $260 per day (Big Spring State

---

[4] Vernon State Hospital admits youth with a primary diagnosis of substance abuse. Less psychiatric counseling is involved in treatment for this diagnosis, therefore cost per day is lower at this hospital for these youths.

Hospital[5]). The institution that had the least costly bedday rate spent the most on bedday costs per year (Vernon) and the institution that had the most costly bedday rate that spent the least on beddays for fiscal year 1988 (Big Spring). One possible explanation for this is that some hospitals had more patients of this age group than the other institutions and therefore, more beddays to drive up overall costs for these institutions, no matter what the daily bedday rate.

The average cost per day in children and adolescent units of state hospitals is approximately $212 per day. Inpatient care for children and adolescents is much more expensive even when compared to other units of these same state institutions ($150 per day). Of all the state hospitals serving this population, Austin State Hospital children and adolescent units seems to be the most representative of the sample. That is, it is close to the average in per bedday cost ($212) and expenditures per year ($4.8 million) for these units.

The average cost per day in the Waco Center for Youth is over 40% less than the cost in the most costly state hospitals. The reason for this difference is not totally clear, but one thing seems clear: The setting at Waco is structured with children in mind, unlike most state hospital grounds, containing a separate unit for children and adolescents. It may be that a more efficient system results when an entire campus of a hospital is devoted to serving youth solely.

The bottom line figure for money spent by Texas Department of Mental Health and Mental Retardation to provide inpatient care for children and adolescents in fiscal year 1989 is over $28 million.

The public dollar figures discussed here are only a small part of the total cost for inpatient care in Texas. The private sector, which can often charge three to four times the daily bedday rate of public institutions, accounts for many more dollars. All Texans are paying for the high cost of inpatient care. Even residents who do not have a child who requires mental health treatment pays in one way or another. Local, state, and federal tax dollars comprise a large portion of TDMHMR's budget. Insurance premiums for health care are affected by the rising cost of inpatient care. Everyone in Texas is affected by cost and effectiveness of this treatment option for children and adolescents. As a result, everyone should be concerned about the choices made in relation to the care for those in need of mental health services.

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[5] These figures include costs for treatment and patient care, rehabilitative services, administrative services, ancillary services and auxiliary services. Costs for fringe benefits for personnel are not included in these figures which are approximately 30 percent of the total personnel cost. Therefore, the figures presented here are probably large under-estimations of the actual cost per day in state hospitals and state centers that have units for children and adolescents.

TABLE I

Children and Adolescent Clients Served and Beddays Used: FY 1987 - FY 1989

FISCAL YEAR	CLIENTS *	% Change	BEDDAYS	% Change
1987	1282	-	148,392	-
1988	1357	5.5%	150,093	1.1%
1989	1565	13.3%	147,758	-1.6%

* Persons 0 to 18 with a mental health diagnosis in the children and adolescent units of TDMHMR Inpatient Units.

Data compiled from the TDMHMR CARE System by Management Analysis and Reporting Unit (MARU) - April 1990.

Table IIa
Sex, Age, and Race of Children and Adolescents in State Hospitals
Fiscal Year 1989

Total											
MALE INFO FOLLOWS											
	0-5	6-11	12-15	16-18							
White	6	118	395	465							
Black	0	20	66	70							
Hispanic	1	14	165	229							
Others	0	1	6	9	1565						
FEMALE INFO FOLLOWS											
	0-5	6-11	12-15	16-18							
White	1	39	219	198							
Black	0	10	48	55							
Hispanic	0	3	118	77							
Others	0	3	5	1	777	2342					
FY '89 Clients	**Age 0-5**	**Age 6-1**	**Age 12**	**Age 16**	**Ages 0-18**		**0-5**	**6-11**	**12-15**	**16-18**	**0-18**
White	7	157	614	663	1441		87.5%	75.5%	60.1%	60.1%	61.5%
Black	0	30	114	125	269		0.0%	14.4%	11.2%	11.3%	11.5%
Hispanic	1	17	283	306	607		12.5%	8.2%	27.7%	27.7%	25.9%
Others	0	4	11	10	25		0.0%	1.9%	1.1%	0.9%	1.1%
All Ages	8	208	1022	1104	2342	2342	100.0%	100.0%	100.0%	100.0%	100.0%

Figure IIa

FY '89 Clients Served — State Hospital & MH State Centers — Age by Ethnic

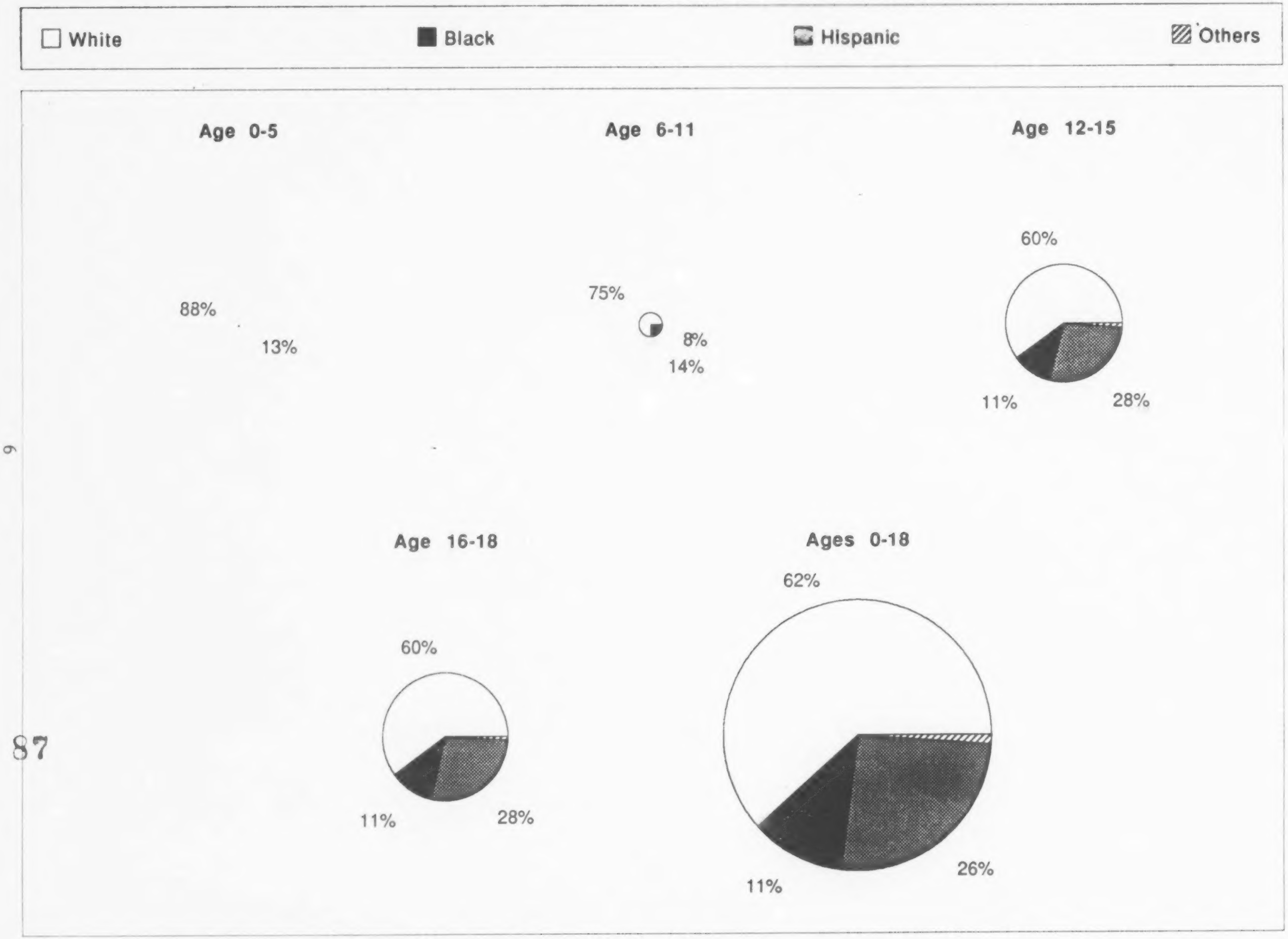


Table IIb
Sex, Age, and Race of Children and Adolescents in State Hospitals
Fiscal Year 1988

Total											
MALE INFO FOLLOWS											
	0-5	6-11	12-15	16-18							
White	7	95	328	402							
Black	0	18	62	76							
Hispanic	2	6	136	218							
Others	0	1	3	3	1357						
FEMALE INFO FOLLOWS											
	0-5	6-11	12-15	16-18							
White	1	27	214	190							
Black	0	14	46	45							
Hispanic	0	3	83	53							
Others	0	2	5	4	687	2044					
FY '88 Clients	**Age 0-**	**Age 6-1**	**Age 12**	**Age 16**	**Ages 0-18**		**0-5**	**6-11**	**12-15**	**16-18**	**0-18**
White	8	122	542	592	1264		80.0%	73.5%	61.8%	59.7%	61.8%
Black	0	32	108	121	261		0.0%	19.3%	12.3%	12.2%	12.8%
Hispanic	2	9	219	271	501		20.0%	5.4%	25.0%	27.3%	24.5%
Others	0	3	8	7	18		0.0%	1.8%	0.9%	0.7%	0.9%
All Ages	10	166	877	991	2044	2044	100.0%	100.0%	100.0%	100.0%	100.0%

Figure IIb

FY '88 Clients Served — State Hospital & MH State Centers — Age by Ethnic

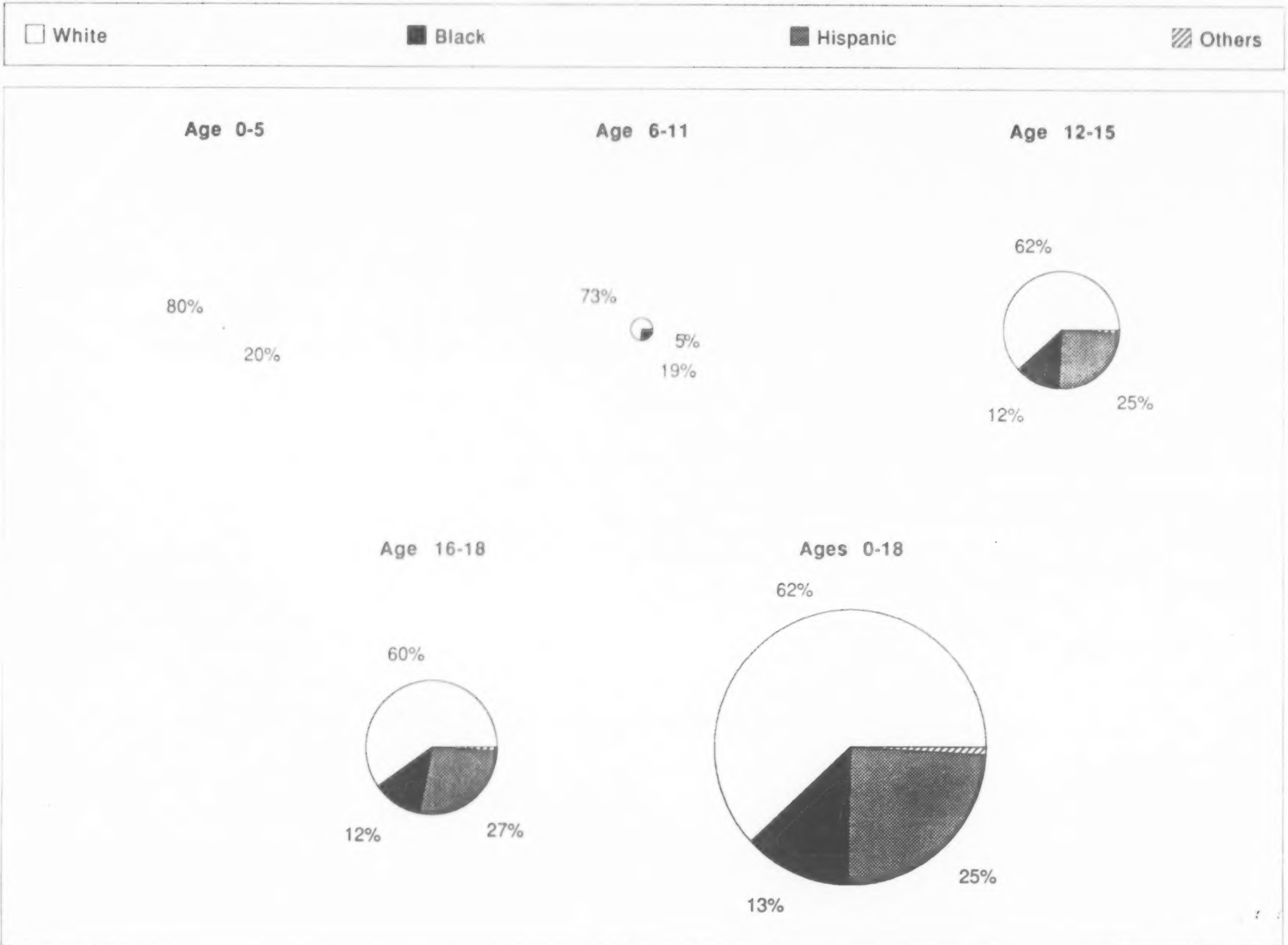


Table IIc
Sex, Age, and Race of Children and Adolescents in State Hospitals
Fiscal Year 1987

Total											
MALE INFO FOLLOWS											
	0-5	6-11	12-15	16-18							
White	7	89	302	389							
Black	0	26	52	68							
Hispanic	2	14	138	187							
Others	0	0	4	4	1282						
FEMALE INFO FOLLOWS											
	0-5	6-11	12-15	16-18							
White	2	27	210	199							
Black	0	15	41	31							
Hispanic	2	3	71	64							
Others	0	2	6	1	674	1956					
FY '87 Clients	**Age 0-5**	**Age 6-1**	**Age 12**	**Age 16**	**Ages 0-18**		**0-5**	**6-11**	**12-15**	**16-18**	**0-18**
White	9	116	512	588	1225		69.2%	65.9%	62.1%	62.4%	62.6%
Black	0	41	93	99	233		0.0%	23.3%	11.3%	10.5%	11.9%
Hispanic	4	17	209	251	481		30.8%	9.7%	25.4%	26.6%	24.6%
Others	0	2	10	5	17		0.0%	1.1%	1.2%	0.5%	0.9%
All Ages	13	176	824	943	1956	1956	100.0%	100.0%	100.0%	100.0%	100.0%

Figure IIc

FY '87 Clients Served — State Hospital & MH State Centers — Age by Ethnic

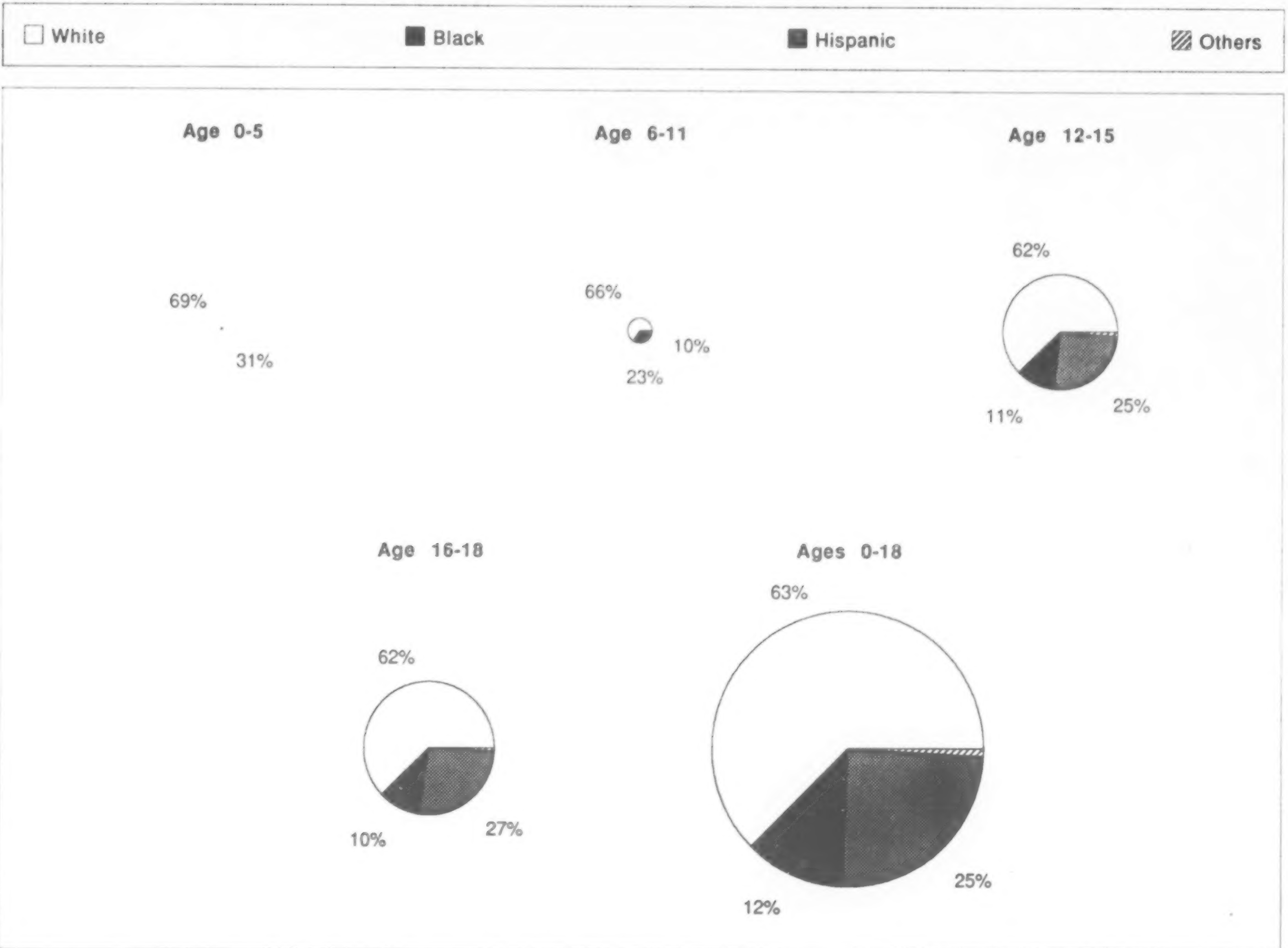


TABLE III

Summary of TDMHMR Children and Adolescent Inpatient Data: FY 1989

HOSPITALS	CLIENTS	BEDDAYS	LENGTH OF STAY	COST/DAY *	TOTAL COST
Austin	311	22,597	73	$212.20	$4,795,083
Big Spring	118	5,877	50	$261.21	$1,535,131
San Antonio	297	9,534	32	$225.71	$2,151,919
Terrell	213	19,397	91	$224.66	$4,357,730
Vernon	621	47,671	77	$155.14	$7,395,679
Wichita Falls	263	11,597	44	$221.20	$2,565,256
Waco Center	243	31,085	128	$185.66	$5,771,241
TOTAL **	1,565	147,758	94	$212.25	$28,572,040

* Cost/day figures did not include fringe benefits for employees so an estimated figure of 25% was added on. This estimated figure of 25% was supplied by TDMHMR.

** Total number of clients does not add up due to some clients being admitted to more than one hospital

Data compiled from the TDMHMR CARE System by Management Analysis and Reporting Unit (MARU) - 3/90.

RESIDENTIAL FACILITY STUDY: SURVEY OF TEXAS RESIDENTIAL FACILITIES SERVING SCHOOL-AGE POPULATIONS-- NATURE OF CLIENTS, LEVEL OF SERVICES AND COSTS

By mandate of the 71st Texas Legislature to evaluate the appropriateness and cost-effectiveness of residential placements of students with emotional disturbance, the Joint Texas Education Agency/Texas Department of Mental Health and Mental Retardation Task Force on Emotional Disturbance conducted this study of residential facilities in Texas which include children and youth with emotional disturbance among the populations served.

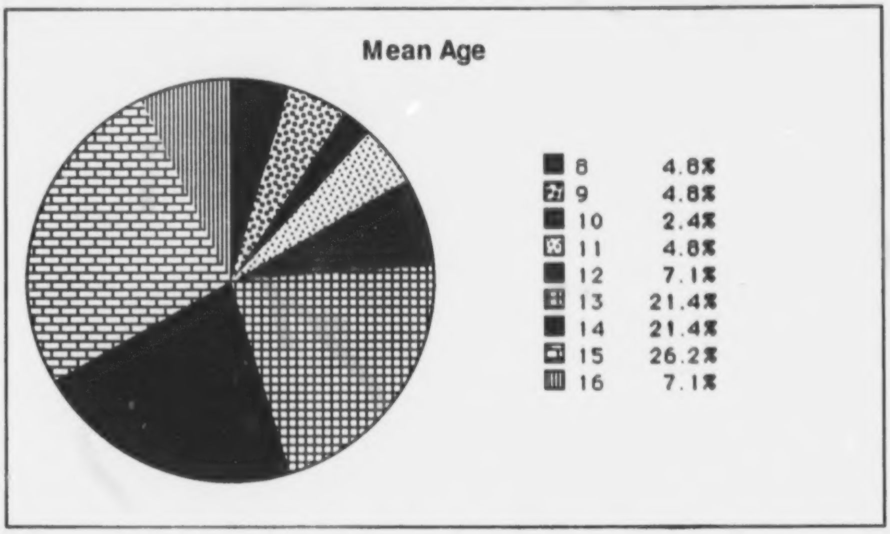
A data collection instrument was designed by the task force and sent to138 public and private in-state residential facilities which serve school-age populations. Specifically, information was collected pertaining to populations served, level of services provided and cost. The instrument was distributed in February 1990. Information was also gathered from the Texas Network for Children database. Based on survey results and on information from the database, the Joint Task Force compiled the following residential facility study.

Forty-four facilities (32%) responded to the survey. Respondents were 60% non-profit and 40% for-profit. The original survey and the list of responding facilities is included in the appendix. Survey findings are presented on the following pages.

Residential Global Population Information

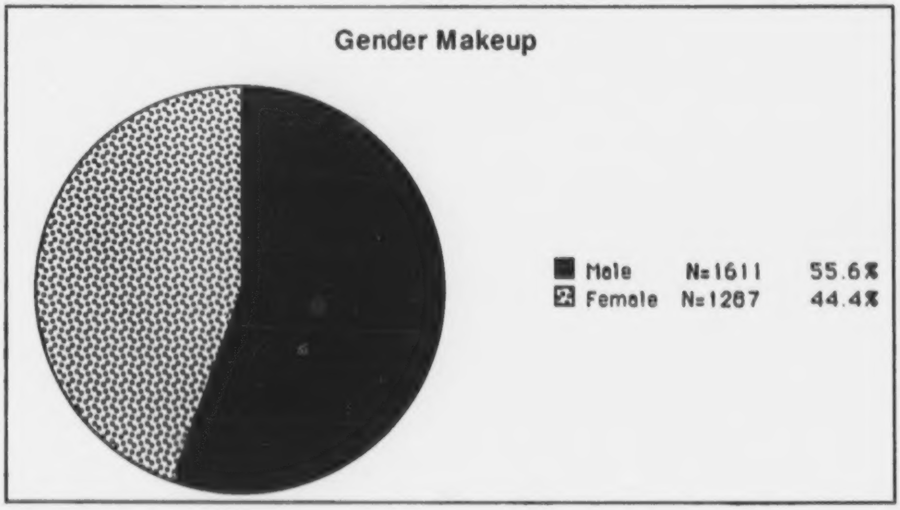
Age Information

Nearly 70% of facilities reported an average age of 13, 14 or 15 years for students with severe emotional disturbance in residential placement, for the reported range of 3 to 21 years.



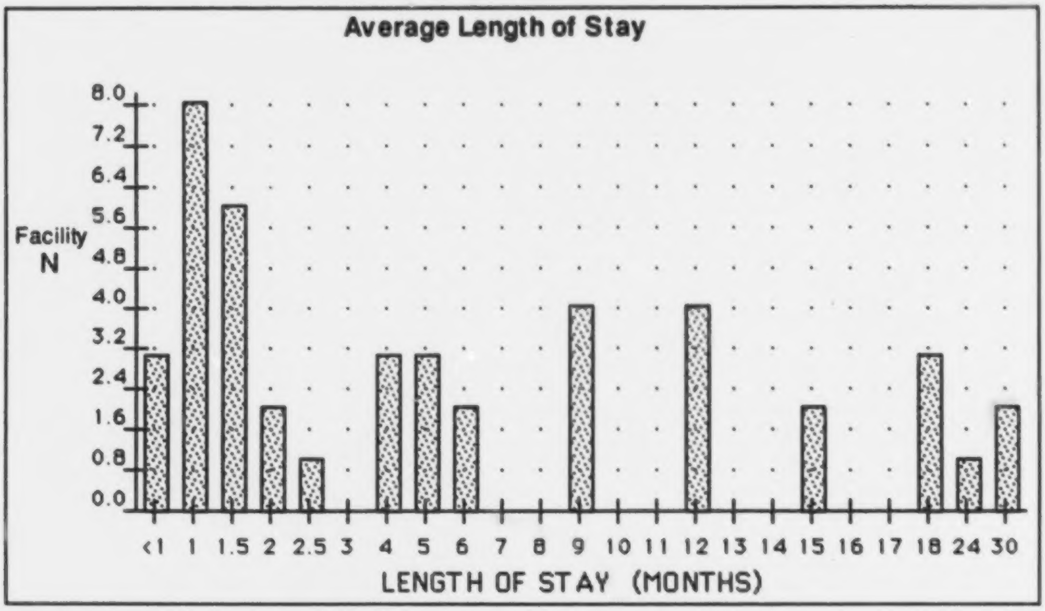
Gender Makeup

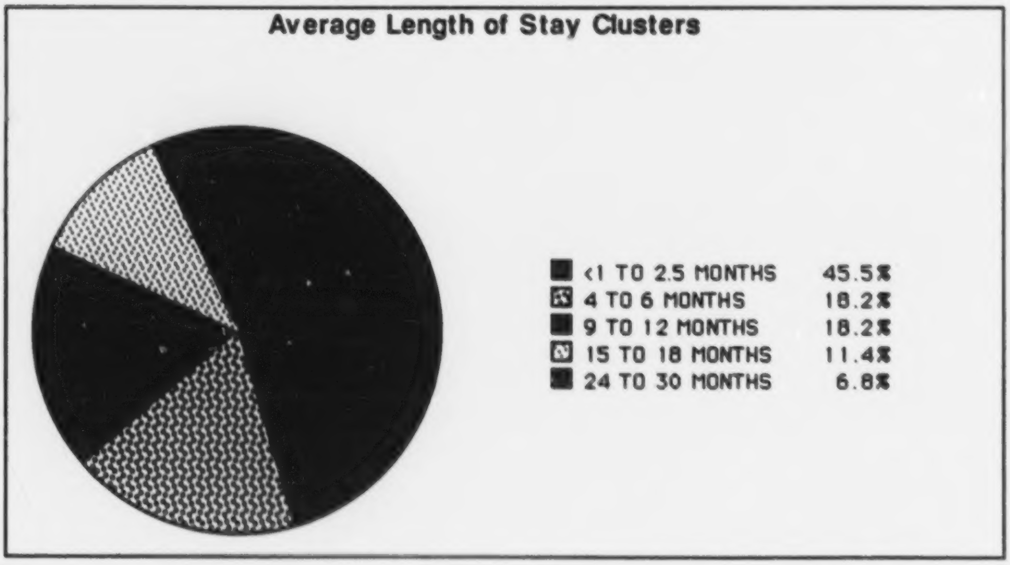
Males with emotional disturbance are over-represented in residential placement compared to the gender makeup of total Texas school-age population (48% female/52% male), but not according to assessments of the gender makeup of special ed or ED populations.



Average Length of Stay

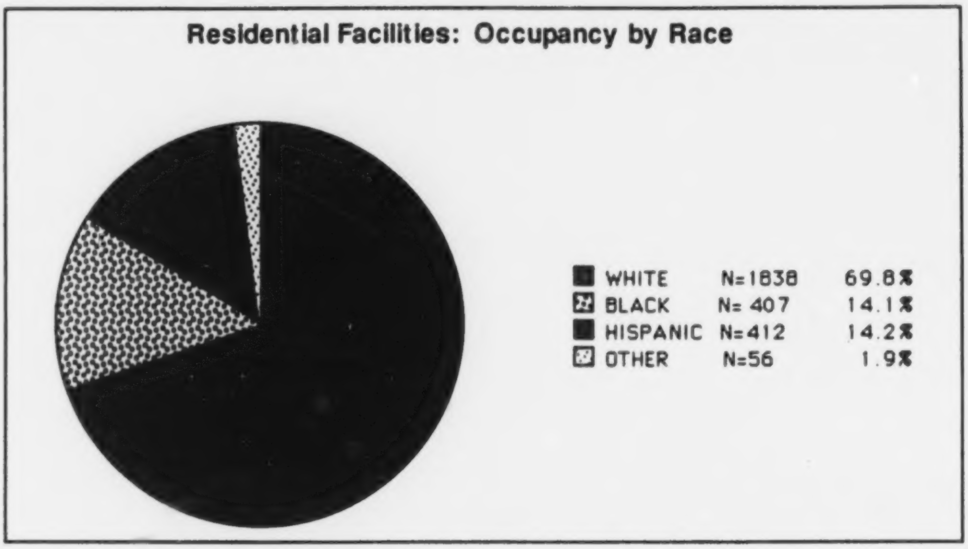
Nearly 50% of facilities reported an average length of stay of less than 2.5 months with average length ranging from less than 1 month to over 30 months.


Average Length of Stay

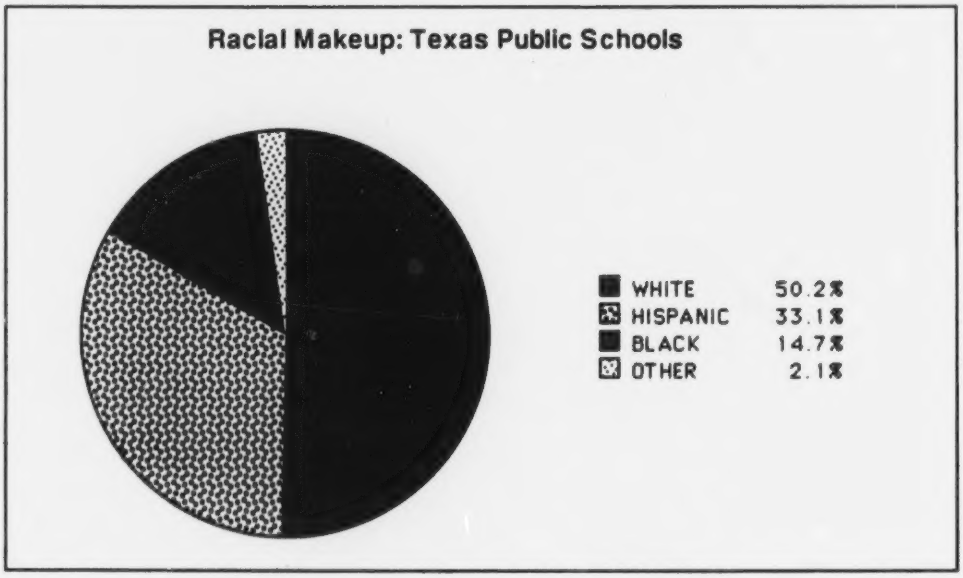

Average Length of Stay Clusters

Racial Makeup

When compared to the racial makeup of Texas public schools, whites are clearly over-represented while Hispanics are under-represented.



Residential Facilities: Occupancy by Race



Racial Makeup: Texas Public Schools

Services Provided by Reporting Residential Facilities

Percentage of Facilities Providing Specific Services, by Type and Duration

Most facilities report providing a full range of psychological services.

Service	% of Facilities Providing
Individual Counseling	100
Group Counseling	100
Family Counseling	93
Medication Management	98
Individual Behavior Modification	80
Group Modification Program	91

Seventy-three percent of facilities provide all services of inquiry.

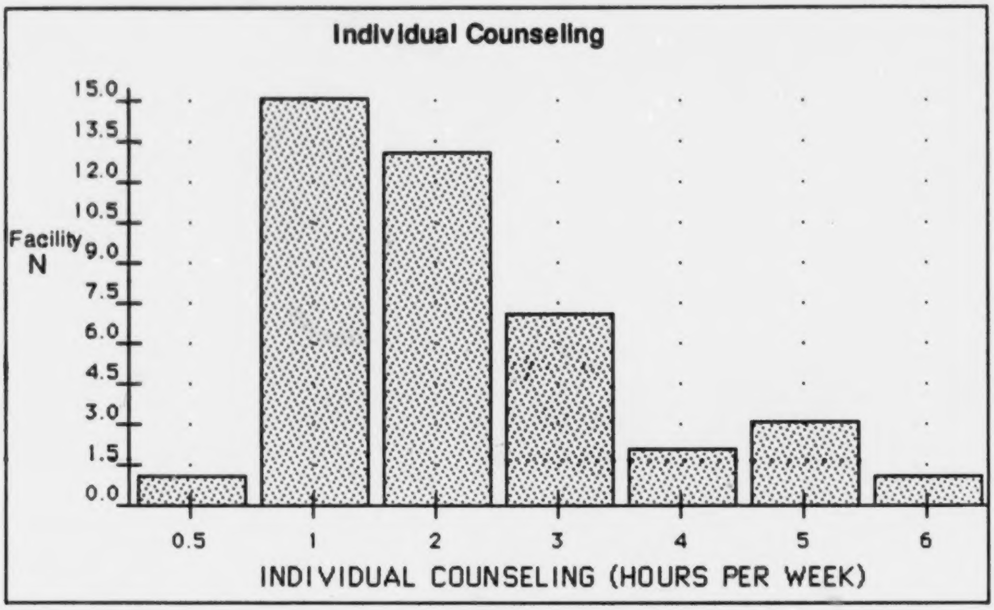
Percent Facilities Providing Specific Clusters of Services

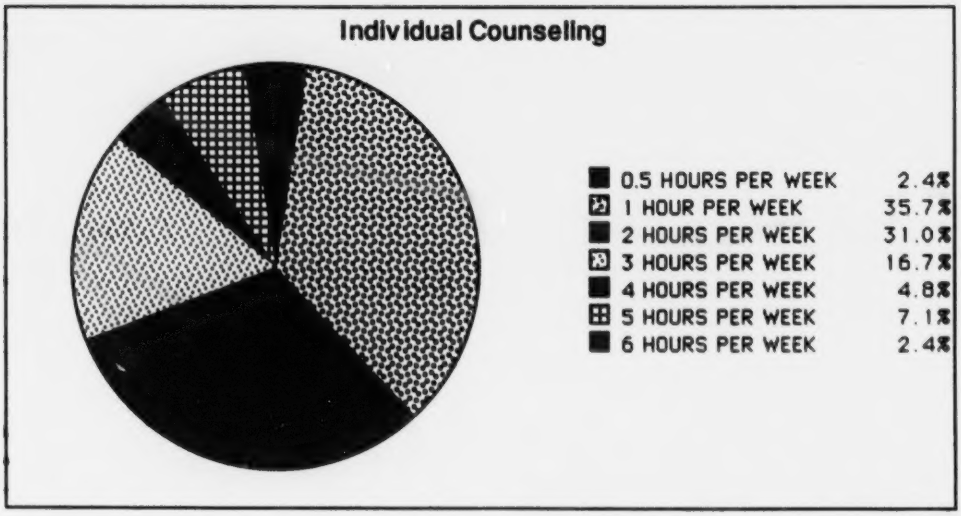
Cluster of Services	% of Facilities Providing
All services: individual counseling group counseling family counseling medication management individual beh mod group mod program	73
All services except individual behavior modification	11
All services except family counseling	5
All services except individual and group behavior modification program	5
All services except group mod pgm	2
Individual, group, family counseling only	2

Individual Counseling (hours per week)

Mean: 2.2
Median: 2.0
Range: 0.5 to 6

Sixty-nine percent of facilities reported providing between 1/2 and 2 hours per week of individual counseling.

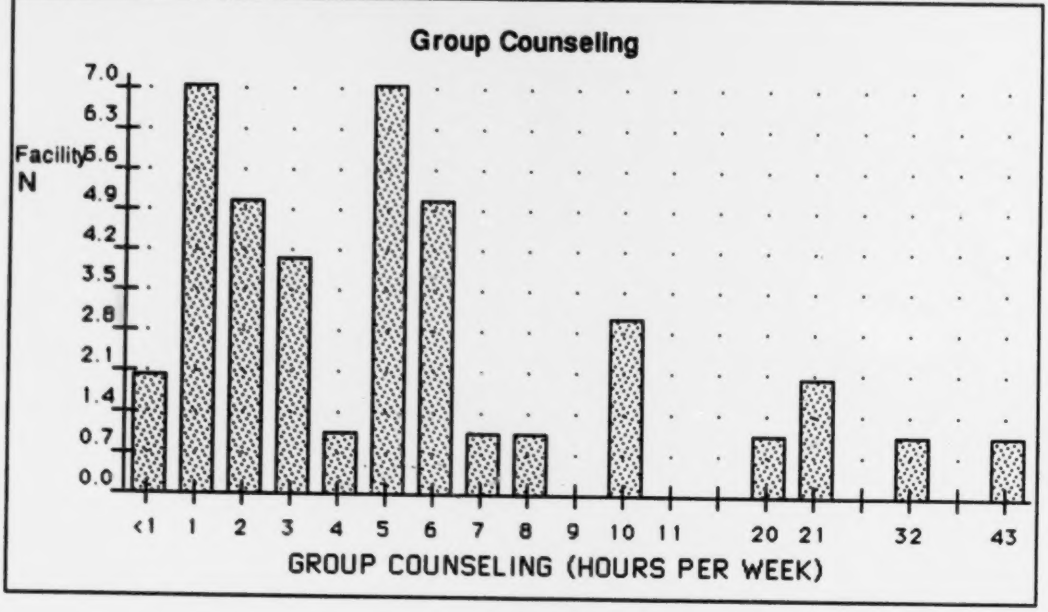


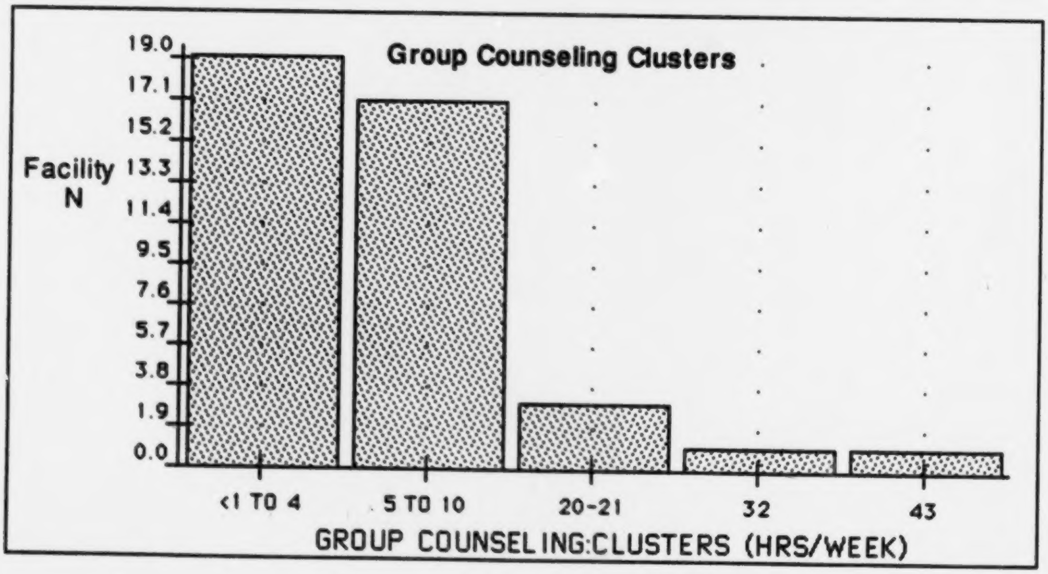


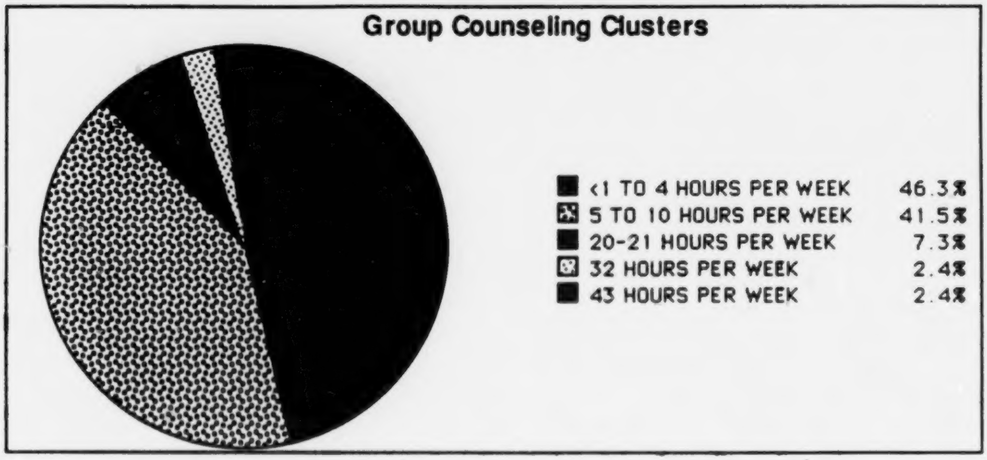
Group Counseling (hours per week)

Mean: 7.0
Median: 5.0
Range: 4 to 43

Eighty-eight percent of facilities reported providing between less than 1 hour and 10 hours per week of group counseling.



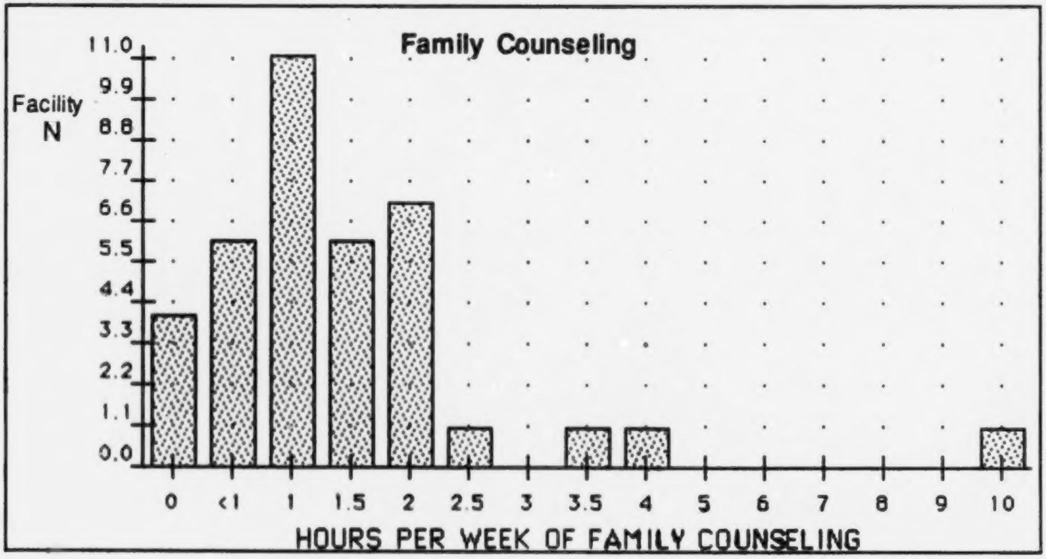


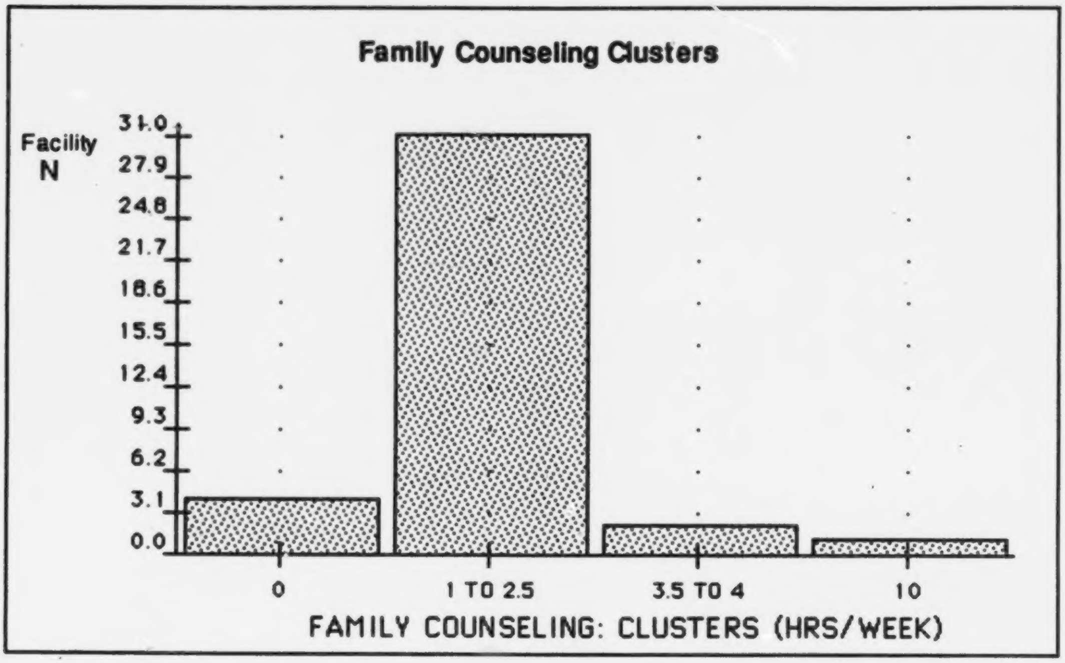


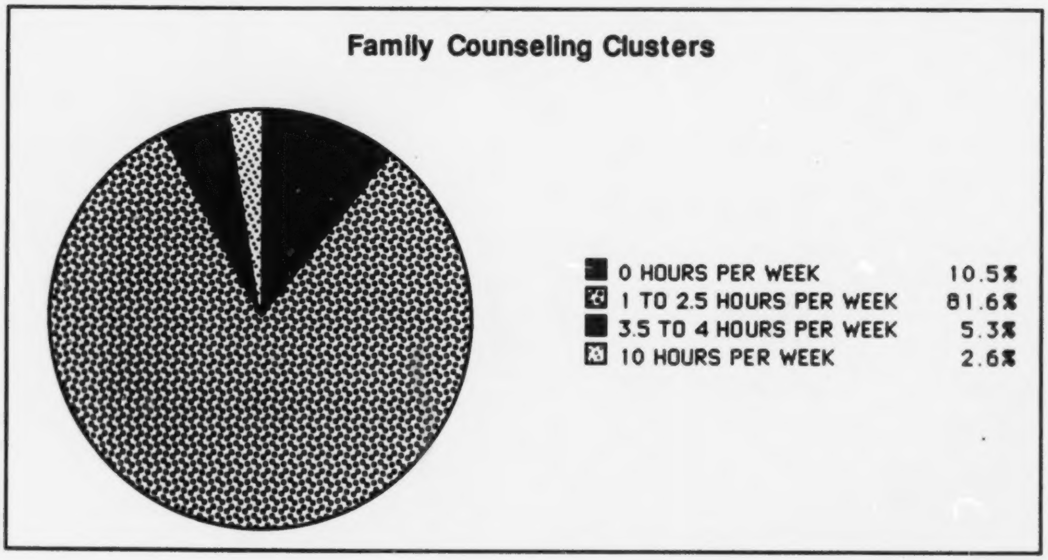
Family Counseling (hours per week)

Mean: 1.5
Median: 1.0
Range: 0 to 10

Eighty-two percent of facilities reported providing 1 to 2.5 hrs per week of family counseling.

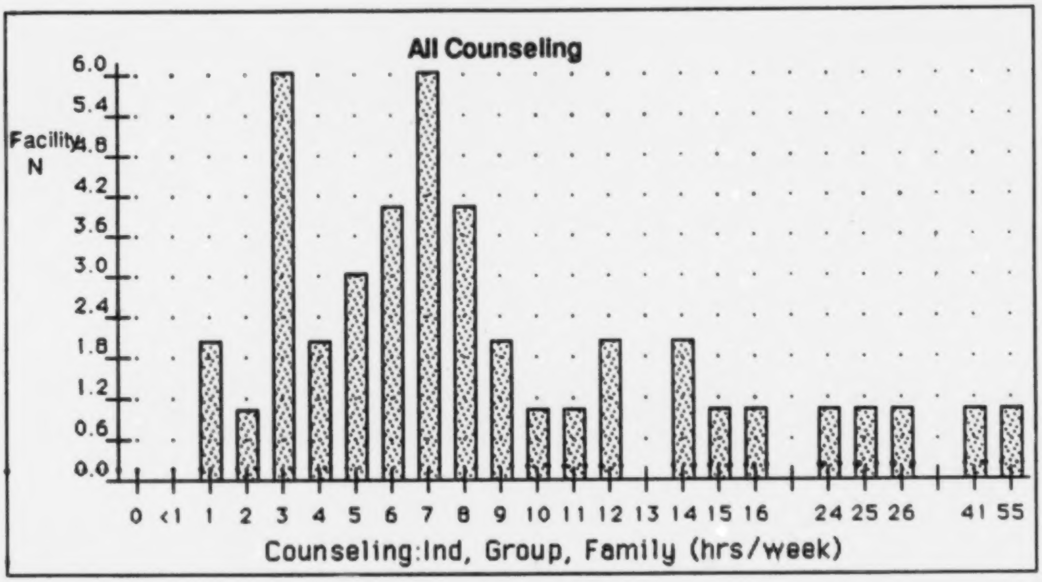


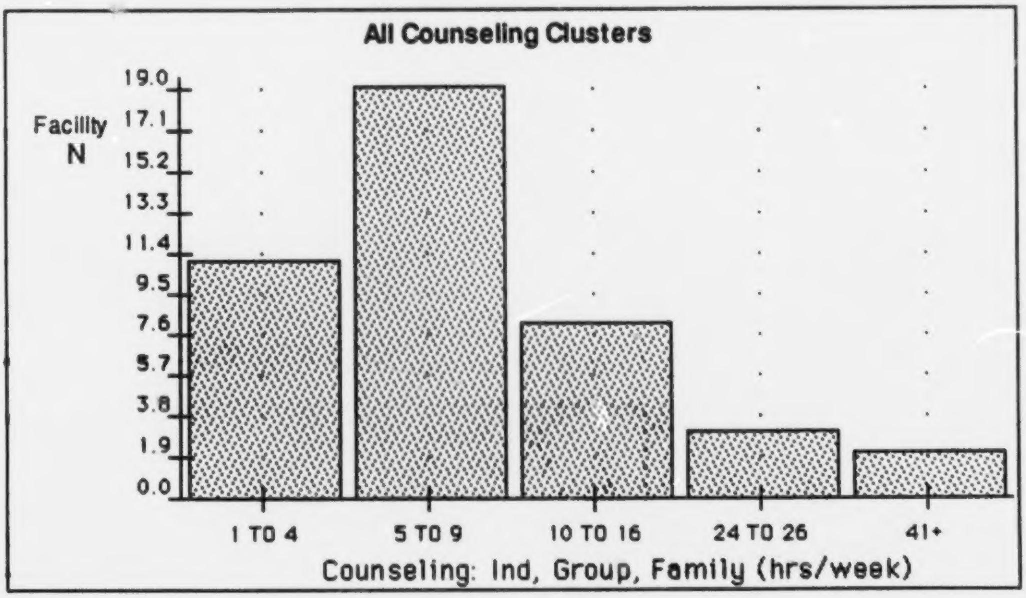

Family Counseling Clusters


Family Counseling Clusters

All Counseling (hours per week)

Mean: 10
Median: 7
Range: 1 to 55





Therapeutic Orientation of Facility Staff

Therapeutic orientations were eclectic rather than narrow with virtually every combination of therapeutic orientations checked. "Behavioral" was the most frequently checked orientation (77%).

Therapeutic Orientations or Clusters of Orientations Reported

Behav'l	Family Cent'd	Systems	Cognitive	Dynamic	Humanistic	Other	# w/ cluster
-----	-----	-----	-----	---->			7
-----	-----	---->				Reality-1	5
-----	-----	-----	-----	---->		Freudian-1	4
-----	-----	---->		---->			3
---->			---->				2
-----	-----	-----	---->				2
-----	-----	-----	---->		---->		1
---->			-----	-----	-----	---->	1
-----	---->		-----	-----	---->		1
-----	-----	---->			---->		1
	-----	-----	-----	-----	---->		1
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	---->		---->			---->	1
		---->				---->	1
		---->		---->			1
---->							1
---->			---->				1
---->						Holistic	1
						Eclectic	1
						Fam Tchng	1
						Ind'l Pgms	1
34	29	29	20	15	8	9	frequency N
77%	66%	66%	45%	34%	18%	19%	frequency %

Note: Respondents tended to check orientation rather than rank them as requested

Over half of the facilities included family-centered and/or systems orientations in addition to behavioral.

Summary Data:	Orientation	#	%
Most frequently checked:	behavioral	34	77
Most frequent dual combination:	behavioral/family-cent'd	25	57
	family-cent'd/systems	25	57
Most frequent triple combination:	behavioral/family-cent'd/ systems	23	52

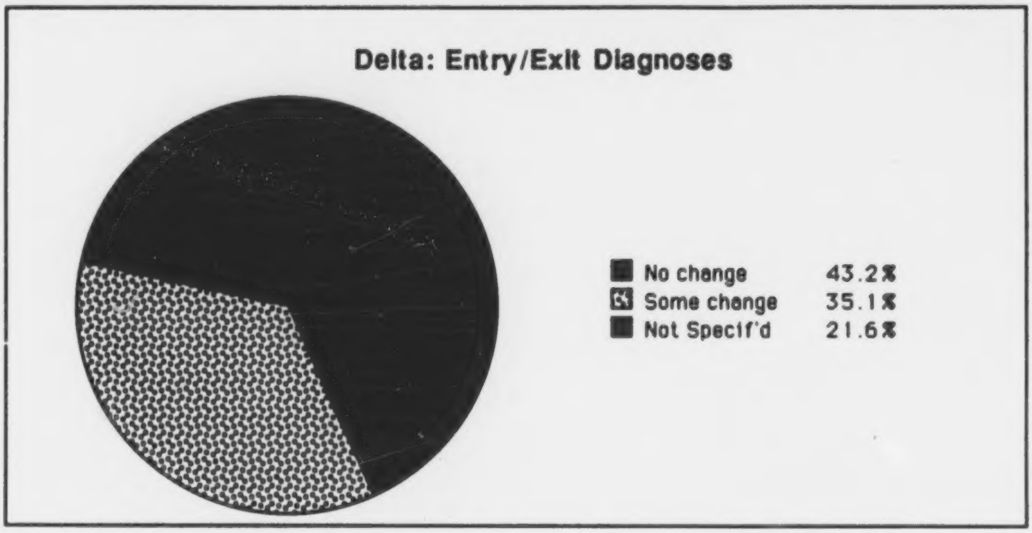
Usual Entry/Exit Diagnoses for Texas Youth in Residential Placement

The usual diagnoses under which youth in each facility were admitted and dismissed are shown in columns A and B. Column C depicts the primary diagnoses of non-special ed youth, i.e. youth not identified as ED upon admittance.

Usual Entry/Exit Diagnoses

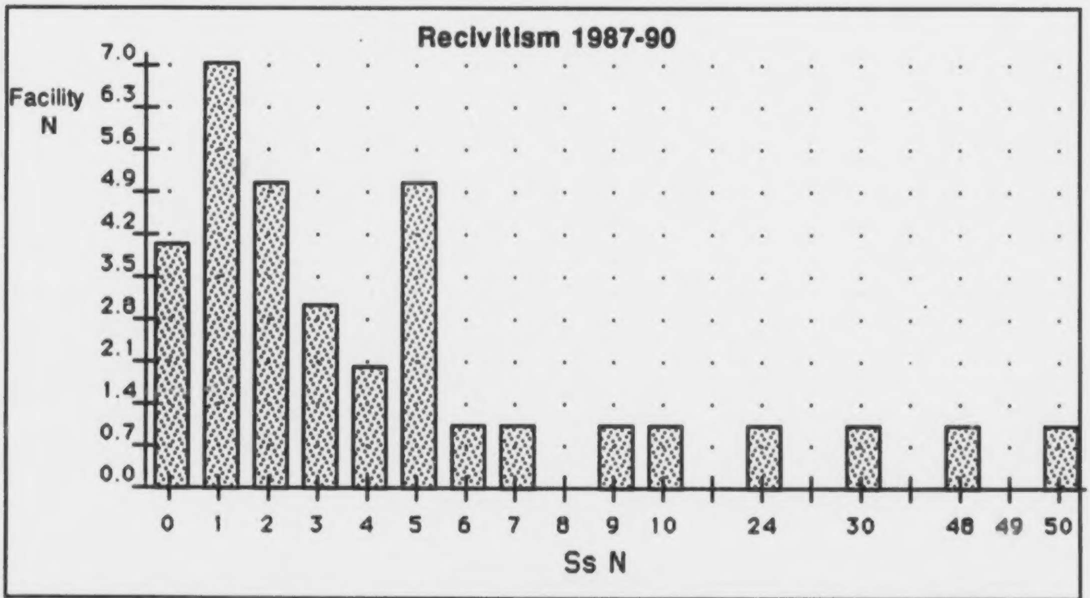
Diagnosis	A Entry(N)	B Exit(N)	C Entry: Non-Special Ed
Conduct Disorder	23	19	15
Major Depression	10	6	9
Dysthymia, depression, neurotic depression	30	18	17
ADHD	13	6	6
Substance Abuse	12	7	10
Oppositional Defiant DO	12	5	9
Borderline Personality DO	8	4	
Bipolar Personality DO	4	1	2
Anxiety DO	6	5	6
Adjustment DO	4	4	4
Post-Traumatic Stress DO	3	1	2
Psychosocial DO	2	0	0
Developmental DO	2	1	2
Parent-Child Problems	2	0	4
Identity DO	2	2	2
Mood DO	2	2	1
Eating DO	2	1	1
Disruptive Behavior DO	1	1	1
Learning DO	1	1	
Mental Retardation	1	1	1
Suicidal Threats	1	0	1
Schizophrenic: undiff chronic	3	2	1
Personality DO NOS	2	2	2
Impulse Control DO	1	1	1
Histrionic Personality DO	1	0	1

Based on the noted admittance and dismissal diagnoses for each responding facility, 43% or facilities report no difference in usual diagnoses from admittance to dismissal.



Recivitism in the Past Three Years (1987-90)

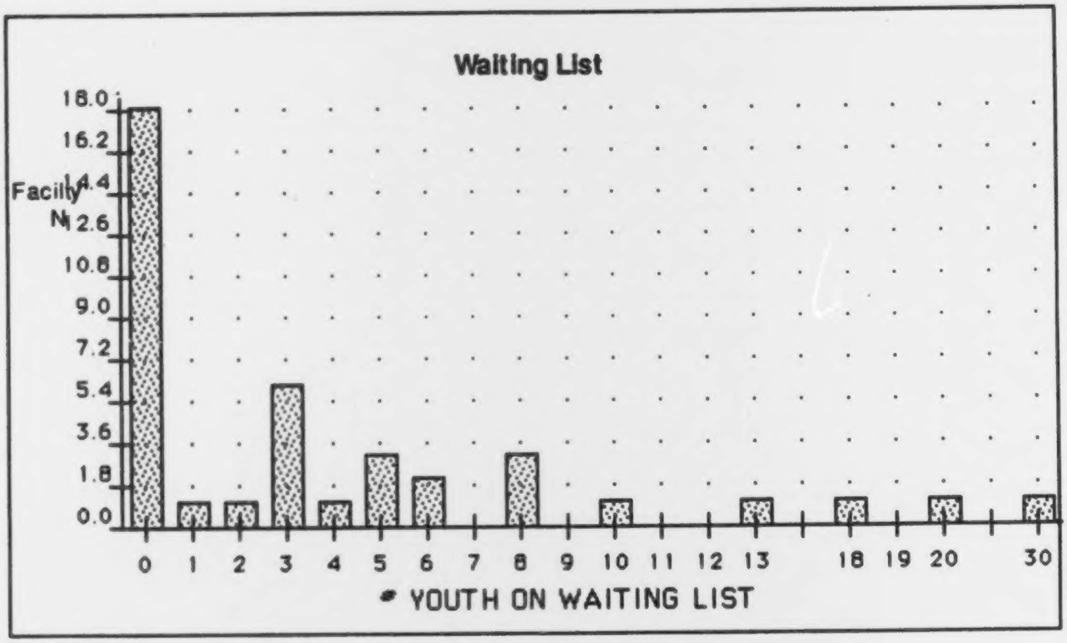
Mean: 9
Median: 3
Range: 0 to 72



Note: Each facility with recivitism at the higher outer limits also has a high annual census.

Waiting List at Each Facility (# Youth)

Mean: 4
Median: 2
Range: 0 to 30



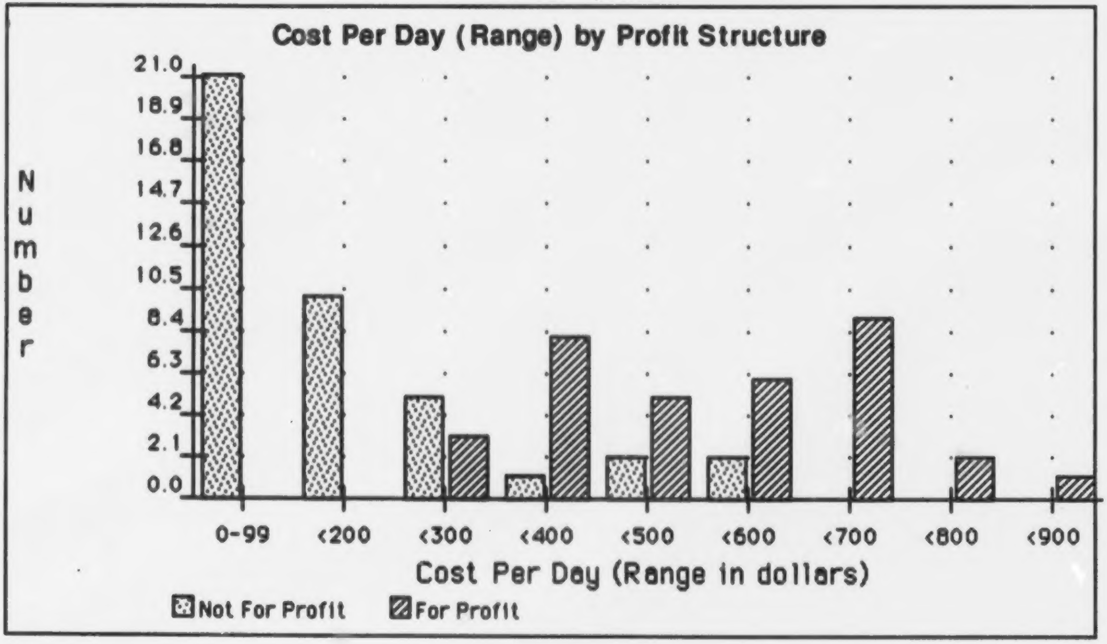
Cost Per Day Data for Residential Placement As Reported by Residential Facilities or As Determined from Texas Network for Children Database

The average cost per day for placement in for-profit residential facilities is nearly 400% higher than the average cost per day in not-for-profit residential facilities.

Summary Data	Not-for-Profit Facilities	For-Profit Facilities
N	41	34
Average Cost Per Day	$127.00	$ 489.00
Median	95.00	$ 450.00
Range	$58-$413	$235-$830

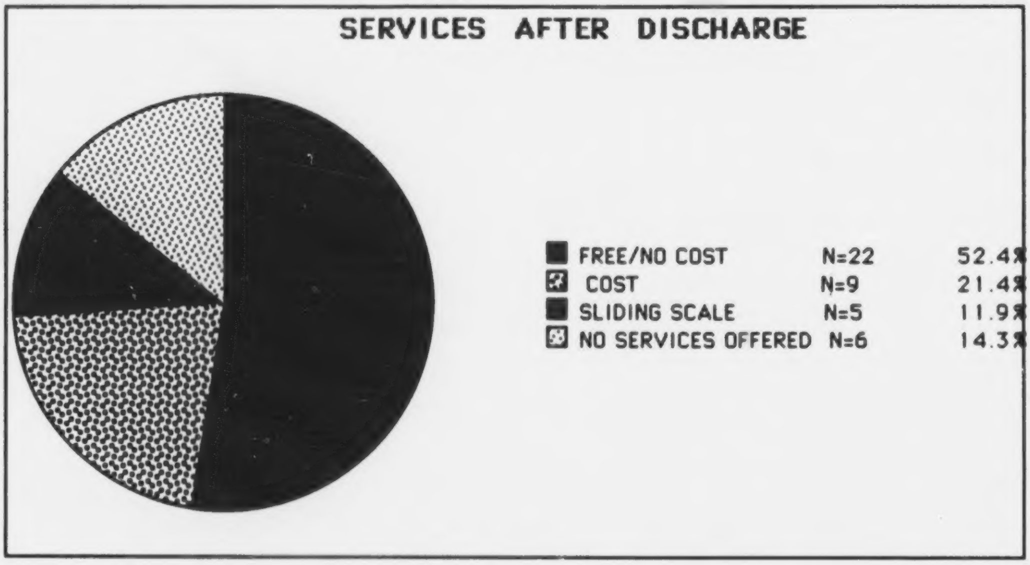
While actual costs per day for both not-for-profit and for-profit facilities occupy the range between $200 and $600, only not-for-profit facilities occupy the $0 to $200 range and only for-profit facilities occupy the $600 to $900 range as shown below.

In addition, 75% of the not-for-profit facilities have per day costs less than $200.

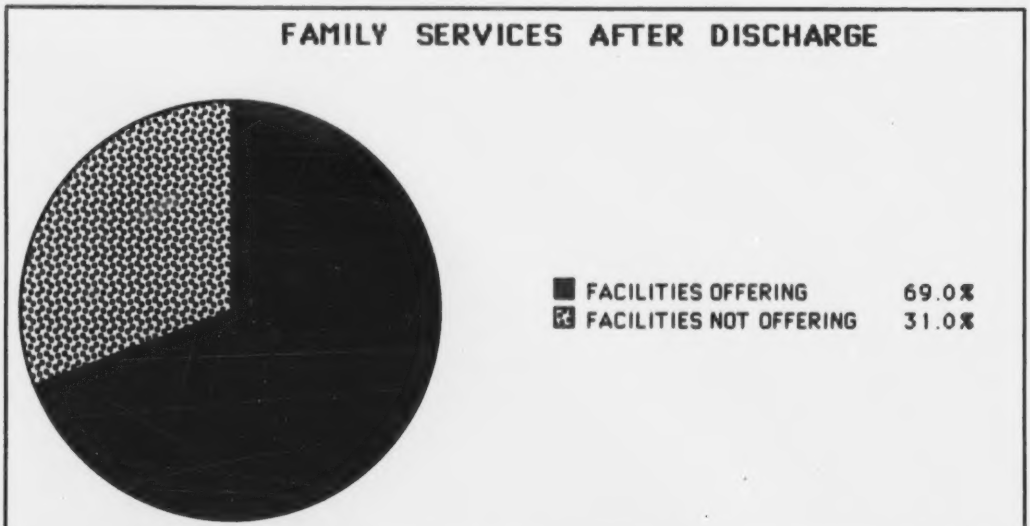


Services Upon Discharge/Follow-Up Recommendations

Services Offered After Discharge/Fee Information
Eighty-five percent of respondent facilities report availability of services after discharge; over half report offering these services at no additional cost.



Sixty-nine percent report offering family services after discharge.



Reported Post-Discharge Services Offered

Type of Service	Cost	Frequency Offered
Aftercare (non-specific)	Free	7
	Sliding Scale	1
Individual Aftercare	Free	5
	Add'l Cost (eg. $75/hr)	2
Multifamily Aftercare	Free	8
	Add'l Cost (eg. $50 & $75/hr)	4
Family Therapy	Free	4
	Sliding Scale	4
	Add'l Cost (eg. $85/hr)	2
Individual Therapy	Free	2
	Sliding Scale	5
	Add'l Cost (eg. $30,60,80, 85, 100/hr)	5
Partial Program	Add'l Cost ($175-323/day)	3
Day Treatment	Add'l Cost (eg. $225/day)	2
Support Group	Free	
child, adolescent		1
parent		4
substance abuse		1
Parent Education/Trning	Free	2
Consultation	Free	2
Family Visits	Free	3
Med Management	Add'l Cost (eg. $50/month)	2
Networking/referrals	Free	5
Educational services	Free	1
School transition services	Free	5
Assistance w/ independent living; may include $$	Free	3
No services offered	NA	6

Recommendations Typically Made for Follow-Up Treatment

Recommendation	Frequency recommended	Percent recommending
Individual outpatient therapy	28	64
Family outpatient therapy	19	43
Continue in hospital's aftercare	8	18
Possible out-of-home placement	7	16
AA/NA & other support groups	6	14
Med management/MD follow-up	5	11
Special ed services	3	7
Day treatment	3	7
Community support system	3	7
Marital therapy	1	2
Family support group	1	2
Multifamily therapy	1	2
Group therapy	1	2
Behavior mgt techniques	1	2
Recreation referrals	1	2
Church groups	1	2
Assistance in independent living	1	2
Parent training	1	2
Sexual abuse trauma support	1	2
Sexual perpetrator trauma support	1	2
Continued DHS relationship	1	2
MHMR referral	1	2

Non-Special Education Population Served

In an attempt to capture the populations placed by parents (i.e. not schools) with insurance coverage (i.e. not public monies), question 15 was developed. However, this question was dropped due to disparity in responses. Specifically, answers were given, in different cases, in non-convertible response units (percentages and numbers).

OUTCOMES OF STUDENTS WITH EMOTIONAL DISTURBANCE IN RESIDENTIAL PLACEMENT FOR EDUCATIONAL PURPOSES
1987 TO 1990

The outcome study was designed to investigate the appropriateness and cost-effectiveness of residential placements of students with emotional disturbance, as part of a mandate by the 71st Legislature to the Joint Texas Education Agency/Texas Department of Mental Health and Mental Retardation Task Force on Emotional Disturbance. The study specifically addresses the discharge outcomes for students.

Focusing upon the 114 residential placements by school districts of students with serious emotional disturbance during the 1987-90 school years, a data collection instrument designed by the task force was sent to all directors of special education in whose districts at least one student with emotional disturbance had been placed.

Information was gathered both from TEA records, from the directors of special education who completed the instrument, and from telephone interviews. The instrument is located in the Appendix.

Response Characteristics

By June 8, 1990, the task force had gathered data on each of the 114 students with serious emotional disturbance in residential placement for educational purposes, a 100% response rate. A total of 51 out of 59 ISDs with ED students in residential placement responded to the survey which was designed to garner information for the three-year period 1987 to 1990. All regions with ED students in residential placement (17/17) are represented.

Surveys, addressed to special education contacts by name in each ISD, were mailed February 9, 1990. Over one-half required follow-up phone contact or a second and sometimes a third mailing.

Note: The responses and the report do not include students in residential placement who are diagnosed as ED/MR (N=13). Preliminary results indicated that results were categorically different for students with this multihandicapping condition. Results for these students should be analysed separately.

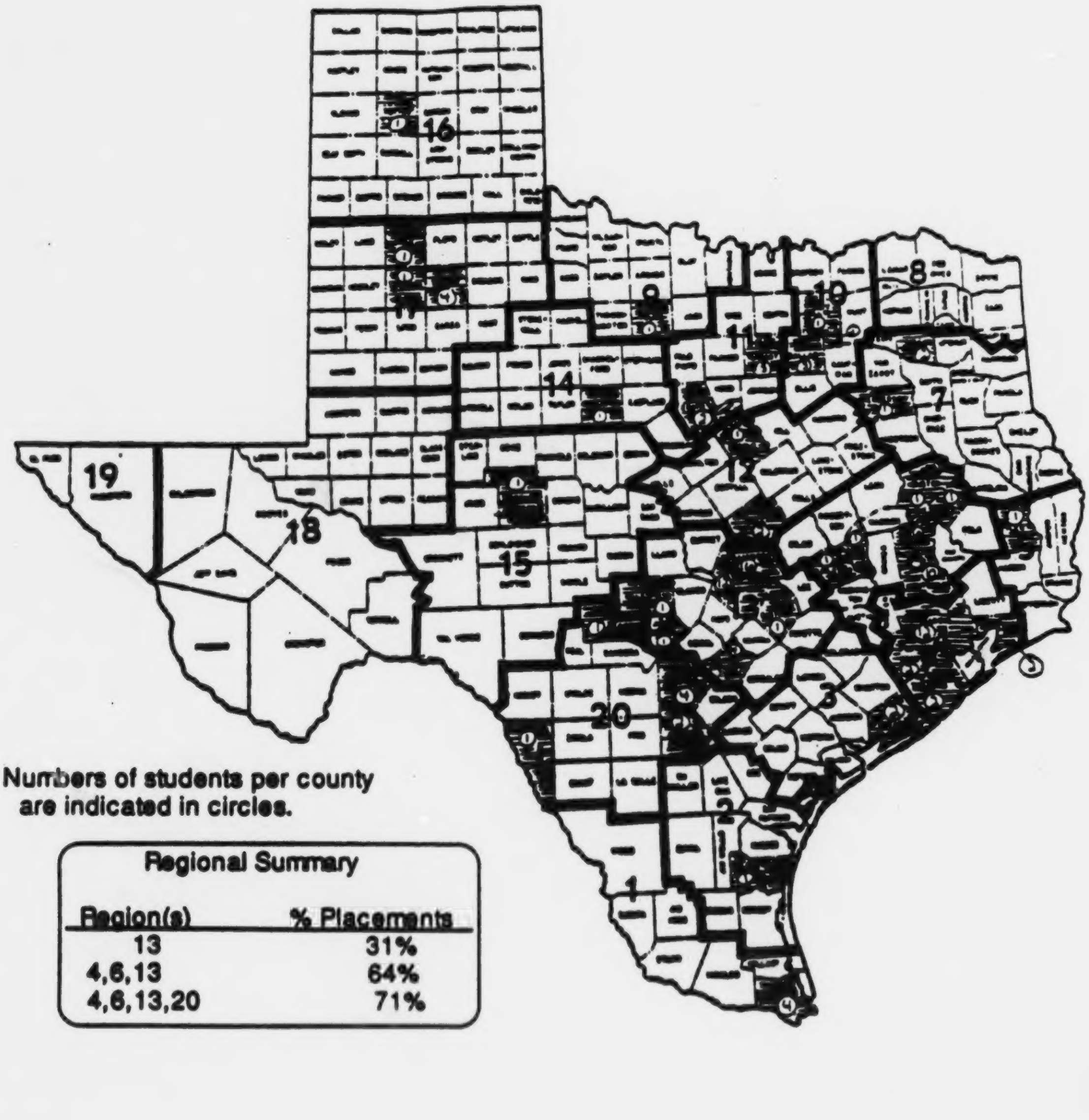
Report Design

The information is reported in three sections.

1. Total Population Information: Information obtained from TEA records about 100% of placements, independent of survey responses.
2. Characteristics of Placement: Information obtained from respondents about the nature of the placements (student characteristics, services, reasons for placement, etc.)
3. Outcome Information: Information gained from TEA records, survey respondents and interviews with special ed directors about individual outcomes and any relationships to other placement variables.

Total Population Information

Statewide Distribution of ED Students in Residential Placement By Region and County


16
8
9
10
11
14
7
19
18
12
15
20
3
2
1

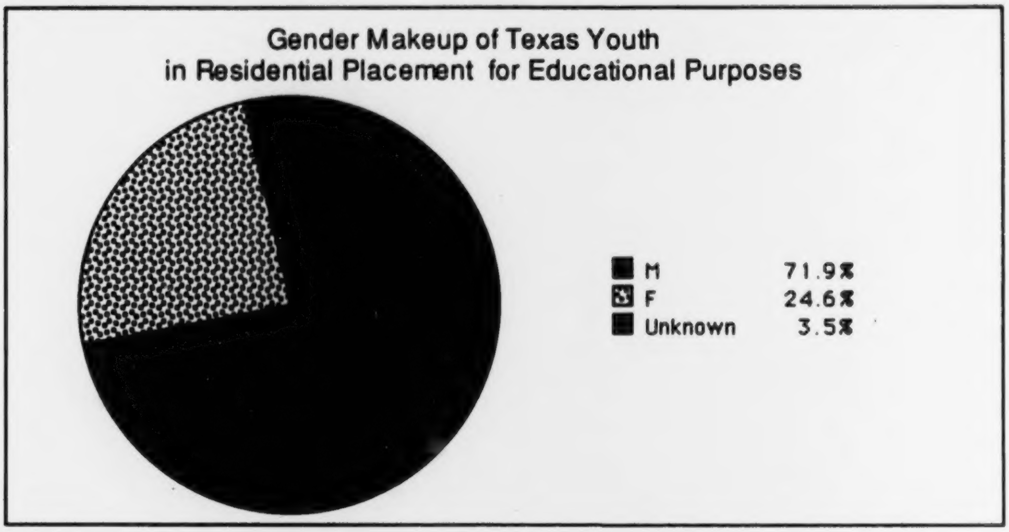
Numbers of students per county
are indicated in circles.

Regional Summary

Region(s)	% Placements
13	31%
4,6,13	64%
4,6,13,20	71%

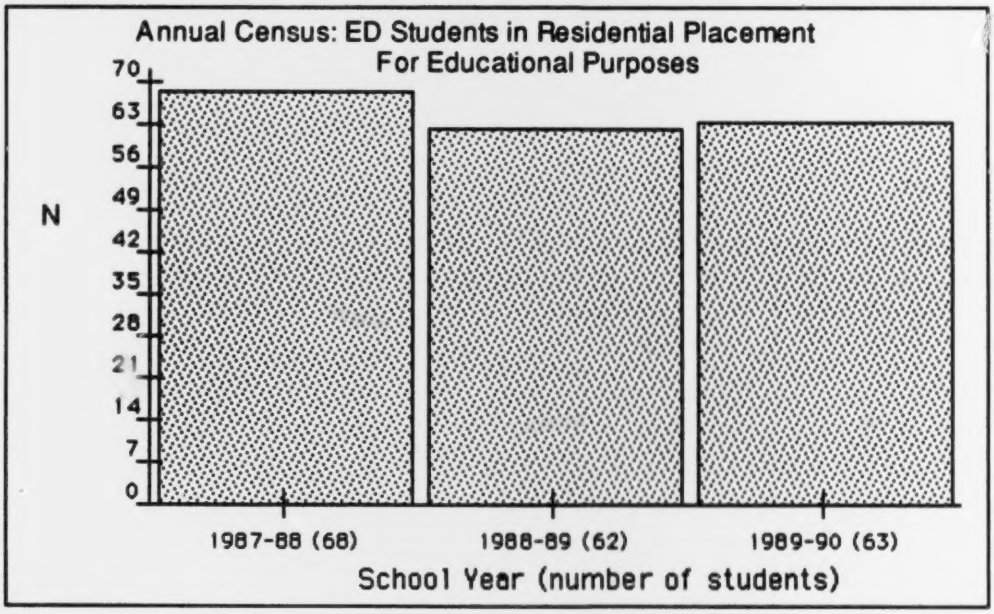
Gender Makeup

Males are over-represented in residential placement compared to the gender breakdown of total Texas school age population (48.3% female/ 51.7% male), but not, according to widely held views, when compared to the special ed or ED populations.


Gender Makeup of Texas Youth
in Residential Placement for Educational Purposes

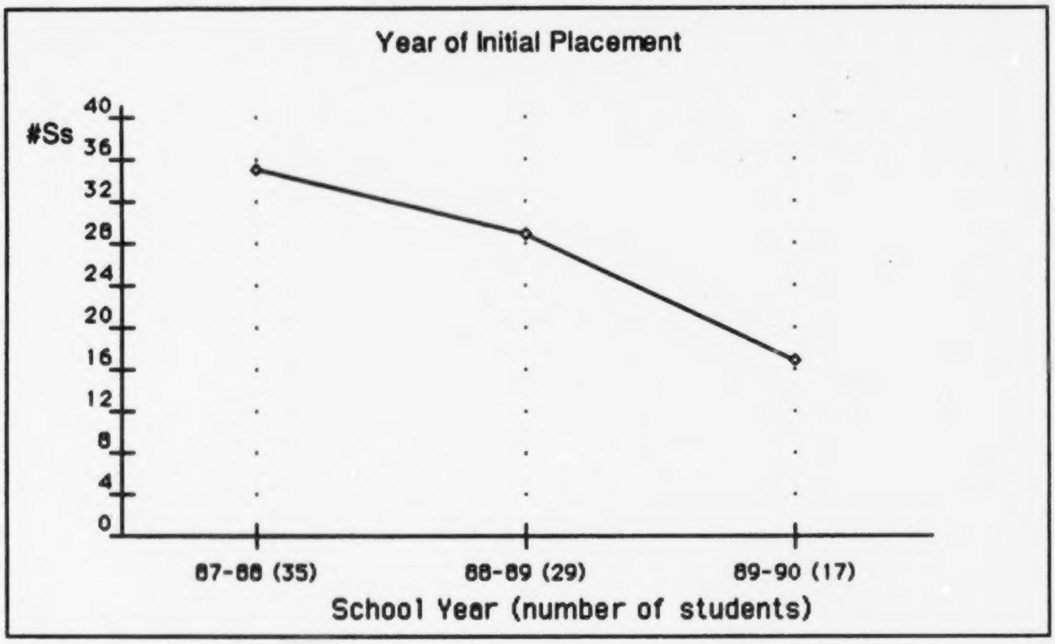
Annual ED/Res Student Census

For the three years studied, there are no significant differences in annual census.


Annual Census: ED Students in Residential Placement
For Educational Purposes

Initial Placements by Year

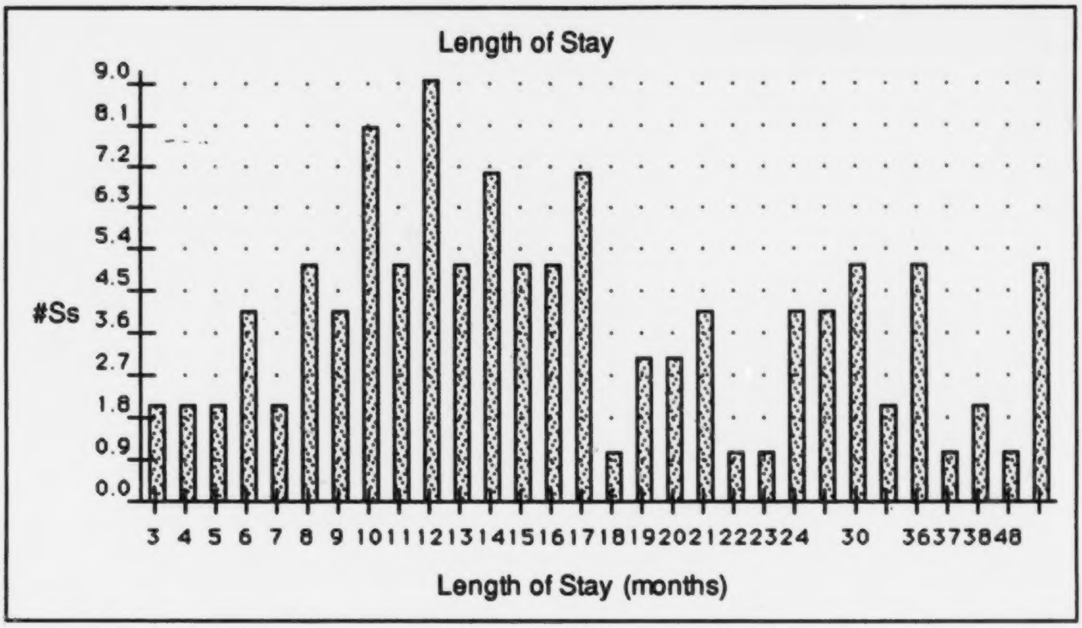
For the three-year period 1987 to 1990, there is a trend of decreasing initial placements since 1987-88. For 1989-90, the number of initial placements was less than half the number in 1987-88.



Length of Stay

Note: Global figures, by necessity, include those currently in placement (N=53). Therefore caution must be used when interpreting average and median length of stay data. More salient information is provided in a later section which relates length of stay to outcome categories.

Average: 18.5 months
Median : 15 months
Range: 3 to 60 months



ISD Characteristics of ED Students in Residential Placement

In summary, there are few apparent relationships between ascertainable ISD characteristics and the residential placement of ED students for educational purposes.

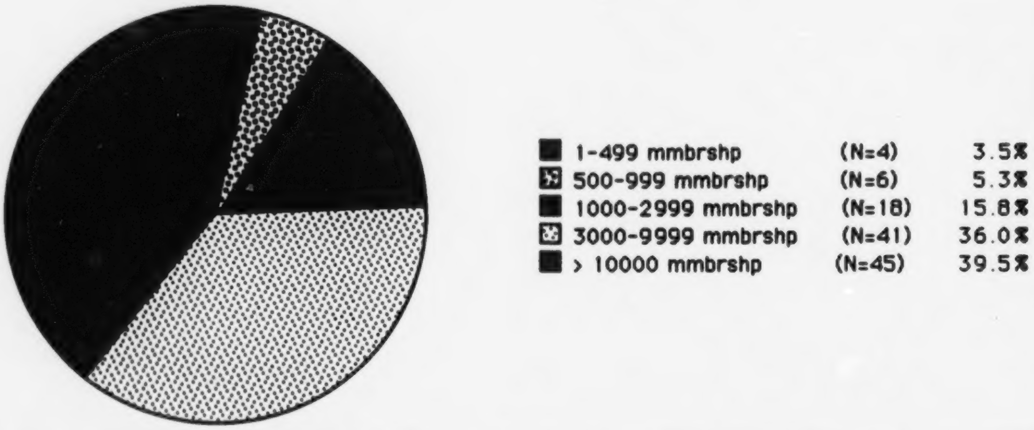
1. There is no relationship between number of placements and high ADA. Seventeen (2%) of ISDs have over 30,000 ADA. Only 5*, or 30%, of these have ED students in residential placement. The average ED identification rate for districts over 30,000 ADA is 0.80%. (*Northeast, Austin, Ft. Worth, Brownsville, Lubbock)

2. There is a relationship between smallest ADA and residential placement. 182 districts (17%) have less than 200 ADA. None, or 0%, placed ED students residentially. The average ED identification rate for districts under 200 ADA is 0.35%.

3. There is no relationship between number of students placed residentially and districts that identify 1% or more of their population as emotionally disturbed. 117 (11%) identify 1% or more of their population as ED. Only 13*, or 11%, placed students residentially. (*Anahuac, Alief, Conroe, Willis, Magnolia, Quitman, Schertz-Cibolo-Univ City, Austin, Eanes, Liberty Hill, Leander, Pleasanton, Northeast)

4. Most residential placements of emotionally disturbed students, in gross numbers, come from the largest ISDs, i.e. ADA greater than 10,000. Placements in this range account for 40% of all placements. Note: This does not control for the numbers of districts in each ADA range, however, making across ADA range comparisons inadvisable.

ED Students in Residential Placement by ADA Range



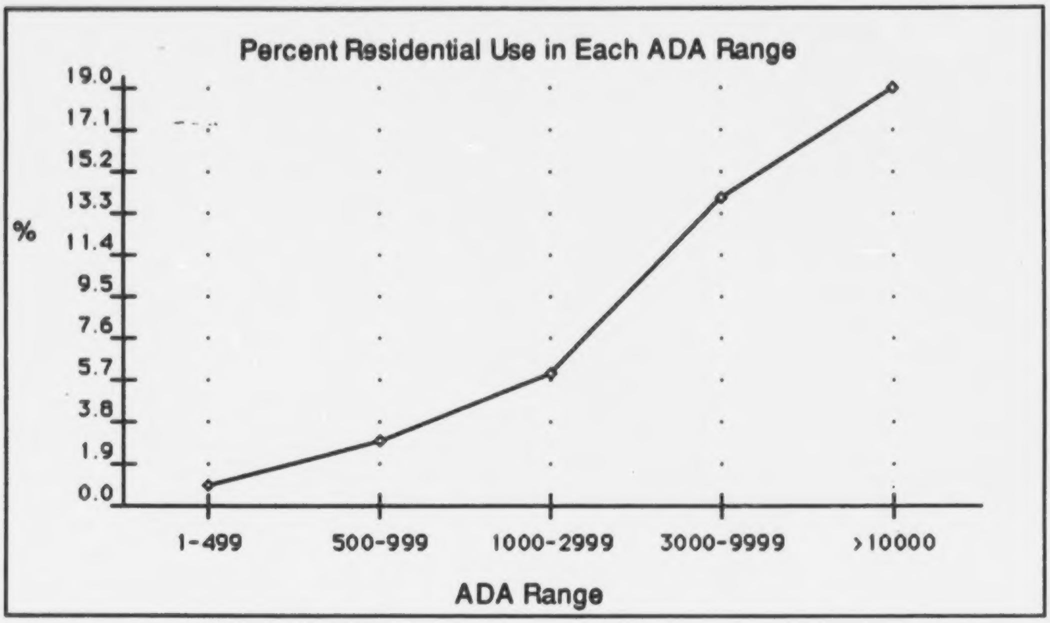
5. The district with the highest number of ED students in residential placement reported that "nothing" would have prevented residential placement for any of their students.

6. Whether or not a district used residential placement over other alternatives may primarily be a factor of the orientation of that special ed director, rather than a factor of district variables such as size, etc.

7. District use of residential placement is more suitable for across-district comparisons. District use of residential placement is highest among districts as shown below; use increases with increasing district size.

District Use of Residential Placement by ADA

ADA Range	No of ISDs	% of total ISDs range comprises	ISDs (N) w/ ED in Residential	Residential Use in this Range
1-49	403	38%	4	1%
500-999	215	20%	6	3%
1000-2999	244	23%	15	6%
3000-9999	138	13%	20	14%
>10000	68	6%	13	19%



8. There are not significant correlations with the Joint Task Force "Counselor Study" which examined availability and type of prevention services offered in school districts in Texas, by the same school district size ranges used here.

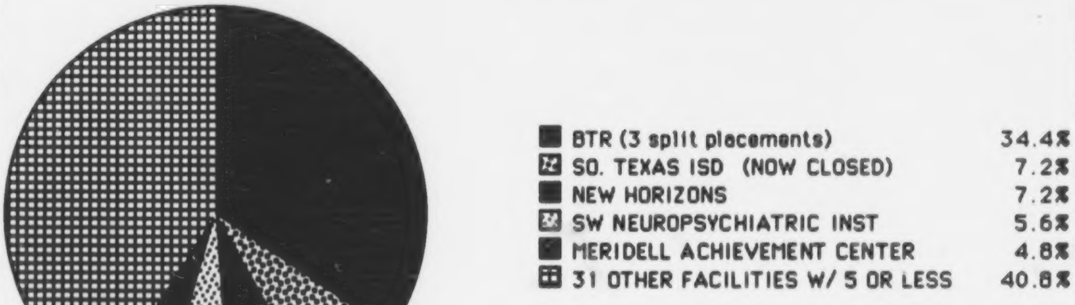
9. There appears to be no relationship between a district's use of residential placement and the location of a community MHMR center within the county of the district. Of 288 districts with a community MHMR center in the same county, only 13 or 5% have students in residential placement. Similarly, of 780 districts without a community MHMR center in the same county, 46 or 6% have students in residential placement.

Residential Facilities Used by Districts Which Place Students Residentially

There is no relationship between a district and its use of a particular facility or facilities. Of the 24 districts with more that one residential placement, 19 tended to vary facility choice for individual cases. The average number of facilities used by districts with more than one placement was 2; range 1-5; median 2.

Few facilities (5) account for a majority (59%) of all residential placements for educational purposes. Five facilities accounted for 59% of all placements; 31 other facilities with 5 or less placements accounted for 41% of all residential placements for educational purposes as shown below. Behavior Training Research (BTR) emerges with 34% of all such placements. All facilities used in all cases over the last three years are represented below.

Facilities Used for Residential Placement for Educational Purposes



Facilities Used for Residential Placements: 1987-88, 1988-89, 1989-90

Facility	# Placements in in this facility	Regions using this facility for plcmt	#Ss from this Rgn
Autistic Treatment Center	1	10	1
The Bayou	1	4	1
Behavior Training Research (BTR)	41	1	1
		4	4
		6	12
		13	22
		17	1
		20	2
Buckner Children's Services	1	16	1
Canyon Lakes	2	17	2
Charter	1	6	1
Charter Plains	1	17	1
Darden Hill School Ranch	1	6	1
Daybreak	1	6	1
DePelchin	5	4	5
Devereaux	4	2	1
		10	1
		11	1
		17	1
Gulf Pines	1	6	1
Health Care Rehab	3	9	1
		12	1
		13	1
Hope Center for Youth	2	4	2
Laurelwood	2	6	2
Laurel Ridge Hospital	1	20	1
Mary Lee Kyle	1	4	1
Mary Lee Live Oak	4	4	1
		13	3
Meridell Achievement Center	6	13	6
The Oaks	2	11	1
		13	1
Odyssey Harbour Inc	2	7	1
		11	1
Methodist Home	1	12	1
New Horizons	9	10	1
		12	2
		13	3
		14	1
		15	1
		17	1
Southwest Neuropsychiatric Institute	7	3	2
		4	1
		10	2
		20	2
St. Theresa's	3	11	2
		14	1
San Marcos Treatment Center	4	6	2
		13	1
		20	1

So. Texas ISD	9	1	2
		4	1
		5	1
		6	1
		11	2
		20	2
Tejas Home for Youth	3	4	1
		7	2
Timberlawn Psychiatric Hospital	1	4	1
Tropical Texas MHMR	1	1	1
Westbranch	1	4	1
Westwood Children's Center	1	11	1
Woods Psychiatric	1	17	1
Woodside Trails	1	7	1
Youth Alternative Center	2	17	1
		20	1
Youth & Family Enrichment Ctr	1	7	1
Total Number of Placements*	**128**		

*Total number exceeds 114 due to split placements.

Facility Choice and Length of Stay

The only apparent relationship between specific facilities and length of stay involves BTR. Of all residential placements for educational purposes, BTR has:

59% (17/29) of all placements 24 months or longer
77% (10/13) of all placements 36 months or longer
100% (4/4) of all placements 60 months or longer

In addition, at BTR:

71% (29) of all residential placements for educational purposes have been in placement 24 months or longer
32% (13) of all residential placements for educational purposes have been in placement 36 months or longer

Characteristics of Placement

Age and Grade When Placed*

Average Age:	13
Median Age:	14
Range:	5-18

Average Grade:	7
Median Grade:	7/8
Range:	K-12

Specific ages and grades of entry are shown below.

Age and Grade When Placed

Age	N	Grade	N
5	1		3
6	2	1	0
7	0	2	1
8	1	3	3
9	3	4	3
10	6	5	10
11	5	6	17
12	13	7	6
13	10	8	13
14	12	9	15
15	16	10	11
16	11	11	3
17	5	12	1
18	1		

Age of Entry and Year of Initial Placement*

There is no apparent trend towards increasing placement of younger children in residential treatment. Specifically, in the last three school years, the numbers of placements of children 6 and under, 8 and under, and 10 and under have dropped from 1987-88 to 1989-90, although not significantly.

Age of Entry in 3 Successive Years

Year	Age													
	5	6	7	8	9	10	11	12	13	14	15	16	17	18
87-88	1			1	1	1	3	1	2	2	6	3	2	1
88-89		1	1			3	1	1	2	5	6	2	1	
89-90					1	2		5	2	3	2	2		

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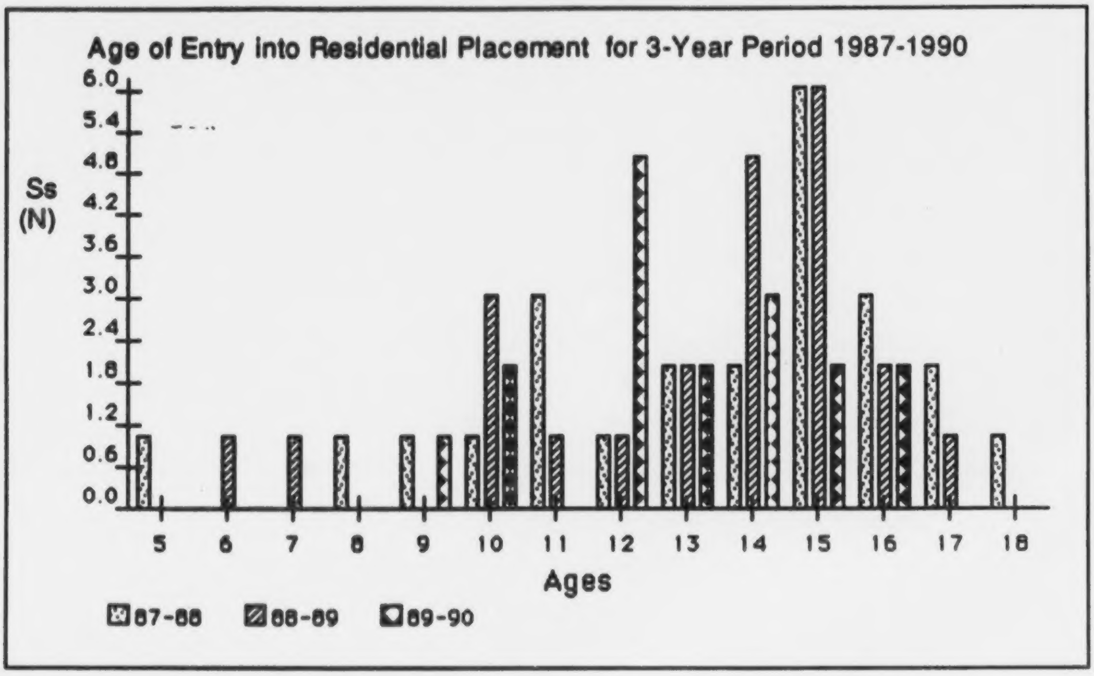
*Based on 86 survey responses (75% rate)



Age of Entry into Residential Placement for 3-Year Period 1987-1990

Major Reasons For Placement*

Summary

Major Category	Frequency Cited
Behavior Related Reasons	199
Family Related Reasons	46
School/Personal History Related	37
Reasons Based on Specific Stated Needs	28

Major Reasons for Placement including Non-Educational Factors

Behavior Related Reasons:	**Frequency Cited: 199**
Outbursts; aggressive behavior; angry, hitting; out of control; explosive behaviors; aggressive; hostility; violence; assaultive; danger to others, peers, staff; homicidal	55
Sexual acting out; bizarre sexual behavior; sexual inappropriateness	11
Suicidal; suic threats; fear student would harm self; suicidal ideation	10
Leaves campus; runs away; hi runaway risk	10
Non-compliance	10
Severe ED, SED	8
Danger to self and others	8
Danger to self; abusive to self; self-destructive tendencies	7
ADD, attentional disabilities	6
Hallucinations	6
Can't function in open setting/PS; req 24-hr structured setting/meds	5
Lack of or poor impulse control	5
Verbal abuse; verbal agression	5
Property abuse; property destruction	4
Stealing	4
Defiant	4
Psychotic; schizophrenia; temporal lobe condition with psychosis	4
Lying	3
Drug involvement/alcohol involvement	3
Depression; major depression	3
Oppositional behavior	3
Anxious; stress	3
Bizarre behavior	2
Erratic behavior	2
Withdrawn behavior	2
Behavior too chronic/acute to be in PSS	2
Physical size	2
Firestarter	2
Inability to relate to others	1
Bizarre hygenic habits	1
Sleeping	1
Low frustration tolerance	1

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*Based on 86 survey responses (75% rate)

Borderline personality disorder	1
Major depression, severe anxiety, hostility following sexual assault/attempted rape by another student	1
Serious & chronic problems; med/neuro/soc/dev/psychiatic/psychol	1
Seizure disorder; neurological implications	1
Fixed delusion system	1
Head injured	1

Family Related Reasons: **Frequency Cited:** **46**

Poor home life/family; dysfunctional family/parents; poor parenting skills; alcoholic parent; parental neglect	13
Concern for parent's/family's safety from physical &/or sexual aggression	10
Family could not control/cope	8
Single parent could not handle	4
Neglect; physical abuse; sexual abuse; psychological abuse at home	3
Student vandalized home	2
Lack of adult/family/community supervision and monitoring	2
Lack of parent/family follow through on plans/guidance recommended by school, DHS, MHMR, etc	2
No parental cooperation; parents refused available services	1
Sibling rivalry	1

School/Personal-History Related: **Frequency Cited:** **37**

Previous residential placement	8
School based alternatives didn't work (e.g. one:one, ABU, counseling, separate campus, special mgt plan involving home, STEP)	6
Family placed; mother's request	4
Survivor of severe infantile abuse; previous sexual abuse	3
District unable to meet needs	3
Prev in JD for sexual assault; DHS placement-Atty General interest	3
Unsatisfactory adoption	2
Lack of educational achievement	2
History of school failure; behavior problems	2
Home bound teacher didn't work out (turned dog loose on her	1
Significant health history	1
MHMR info	1
Parents and public agencies unable to effect change	1

Reasons Based on Stated Needs For: **Frequency Cited:** **28**

Behavior therapy as primary intervention; indepth behavior management training; 24-hr structure/supervision/mgt. pgm/ lock-up placement	16
Family counseling, case management, community involvement	3
Adequate support services to family and home that are not available	2
Proper med control/medical evaluation	2
Affordable/available counseling from MHMR	2
Vocationaltraining	1
Individual instruction	1
Crisis intervention	1

Services, Programs, and Conditions Cited That Would Have Prevented Placement *

By far, respondents believe that the availability of community-based services for student and family would have prevented residential placement in individual cases. The frequency of conditions cited that respondents believe would have prevented residential placement are noted below; major areas are in boldface.

Noted under "Nothing" (would have prevented residential placement) is that almost 50% of this response came from one ISD which had the highest number of residential placements for a single ISD.

Regarding the remaining reponses in the"Nothing" category, or in "Nothing Else" (i.e. everything else already tried), there were no relationships between district of origin, prevention measures, reasons for placement or outcome.

Summary

Major Category	Frequency Cited
Service Related	52
Other: (nothing)	28
School Related	18
Family Related	9

Services, Programs, Etc., That Would Have Prevented Residential Placement

SERVICE RELATED	**Frequency Cited: Total: 52**
Availability of outpatient or community-based services	21
Publicly funded programs	
Day treatment/with family therapy	
Therapy/intensive therapy	
Respite care	
Family counseling, family caseworker	
Weekly visits, home monitoring	
In-home assistance	
Parent training	
Medication monitoring, med psychotherapy for parent	
Follow-through on counseilng/training sessions	
Individual counseling	
24-hour within-district placement with behavior therapy	14
Intervention by DHS/foster home plaecment/group home placement	8
Adequate MHMR services	6
Behavior therapy with management program, with support services to family at home and in community	2
Another adoptive family	1

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*Based on 86 survey responses (75% rate)

OTHER:	Frequency Cited: Total: 28
Nothing (Note: 9 are from 1 ISD)	20
Nothing else, tried everything	8

SCHOOL RELATED	Frequency Cited: Total: 18
Certified ED teacher/classroom	13
More local trained personnel/suff. $$ to ISD to hire trained staff...	4
Special class for ED elementary students	1

FAMILY RELATED:	Frequency Cited: Total: 9
Stable home environment, well supervised	5
Stronger parent discipline and control	2
Parent cooperation	1
Availability of constant supervision	1

Services Obtained from Residential Placement*

The frequency of services cited below includes some categories that overlap, e.g., the combined category of related services is equivalent to the two single categories of behavior therapy and counseling.

Services Obtained from Residential Placement

Services	Frequency reported:
Residential services	53
Educational services	46
Behavior therapy/behavior management	42
Counseling	29
Related services (Behavior therapy & counseling)	15
Therapy/therapeutic services/therapeutic milieu	14
Individual therapy/ individual counseling	10
Recreational services	9
Family therapy	8
Group therapy	7
Language/speech therapy	6
Consultation with psychologist	4
Parent education and counseling	3
Social work services	2
Psychiatric consultation	2
Medical services	2
Social treatment	1
Case management	1
24-hour locked therapeutic facility	1
Supervision	1

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*Based on 86 survey responses (75% rate)

Cost Per Month for Each Student in Residential Placement for Educational Purposes

Summary

	Including CHAMPUS	Not Including CHAMPUS
Average Cost/Month:	$6316	$6304
Median Cost/Month:	$6263	$6245
Range:	$763 to 15,893	$763 to 15,863

Cost Per Month for Each Residential Placement for Educational Purposes

$763	BTR
$813	South Texas ISD
$1293	South Texas ISD
$1275	South Texas ISD
$1303	South Texas ISD
$1600	Hope Center for Youth
$1691	Tropical Texas MHMR
$1812	Mary Lee
$1850	Hope Wilderness Center
$1870	Hope Wilderness Center
$1890	New Horizons
$1903	Mary Lee
$1915	Darden Hill School Ranch
$1985	New Horizons
$2094	Youth Alternatives Center
$2261	ELAN
$2313	Youth & Family Enrichment Ctr.
$2516	Tejas Home for Youth
$2555	Woodside Trails
$2619	Buckener Children's Services
$2745	New Horizons
$2961	Mary Lee
$2978	St. Teresa's
$2998	St. Teresa's
$3194	Mary Lee
$3194	Tejas Home for Youth
$3229	Odyssey Harbour
$3284	Mary Lee
$3400	Mary Lee
$3557	Odyssey Horbour
$3669	New Horizons
$3722	New Horizons
$3802	New Horizons
$3863	Canyon Lakes
$3892	New Horizons
$3916	New Horizons
$4162	De Pelchin
$4299	De Pelchin
$4375	Southwest Neuropsychiatric Inst.
$4419	Canyon Lakes
$4450	Daybreak
$4471	BTR
$4596	De Pelchin
$4829	Autistic Treatment Center

$4829	Southwest Neuropsychiatric Inst.
$4840	Southwest Neuropsychiatric Inst.
$5048	BTR
$5063	BTR
$5171	BTR
$5349	Devereaux
$5399	Timberlawn Psychiatric Hospital
$5555	BTR
$5683	Southwest Neuropsychiatric Inst.
$5931	BTR
$6021	BTR
$6094	De Pelchin
$6245	Westbranch
$6263	Southwest Neuropsychiatric Inst.
$6294	Devereaux (89% CHAMPUS)
$6388	Southwest Neuropsychiatric Inst.
$6448	BTR
$6448	BTR
$6537	BTR
$6630	BTR
$7219	BTR
$7272	BTR
$7309	BTR
$7435	BTR
$7483	BTR
$7483	BTR
$7483	BTR
$7498	BTR
$7512	BTR
$7573	BTR
$7752	BTR
$7795	Meridell Westwood
$7817	BTR
$7868	BTR
$8046	BTR
$8053	BTR
$8120	BTR
$8200	Meridell Westwood
$8213	BTR
$8250	Meridell Westwood
$8518	Southwest Neuropsychiatric Inst.
$8669	Meridell Westridge
$8825	BTR
$9010	Devereaux
$9011	BTR
$9125	BTR
$9125	BTR
$9204	BTR
$9382	BTR
$9519	Meridell
$9612	BTR
$9817	Meridell
$9825	BTR
$10060	San Marcos Treatment Ctr.
$10068	BTR

$10600	Woods Psychiatric Center
$10233	San Marcos Treatment Ctr.
$10565	BTR
$10647	BTR
$10798	BTR
$11133	BTR
$11292	San Marcos Treatment Center
$11569	BTR
$12059	Laurelridge Hospital
$12907	Healthcare Rehab
$13749	BTR
$13775	Oaks Treatment Center
$14524	HCI Laurelridge
$15863	Healthcare Rehab
$15893	Oaks Trtmt Ctr. (96% CHAMPUS)

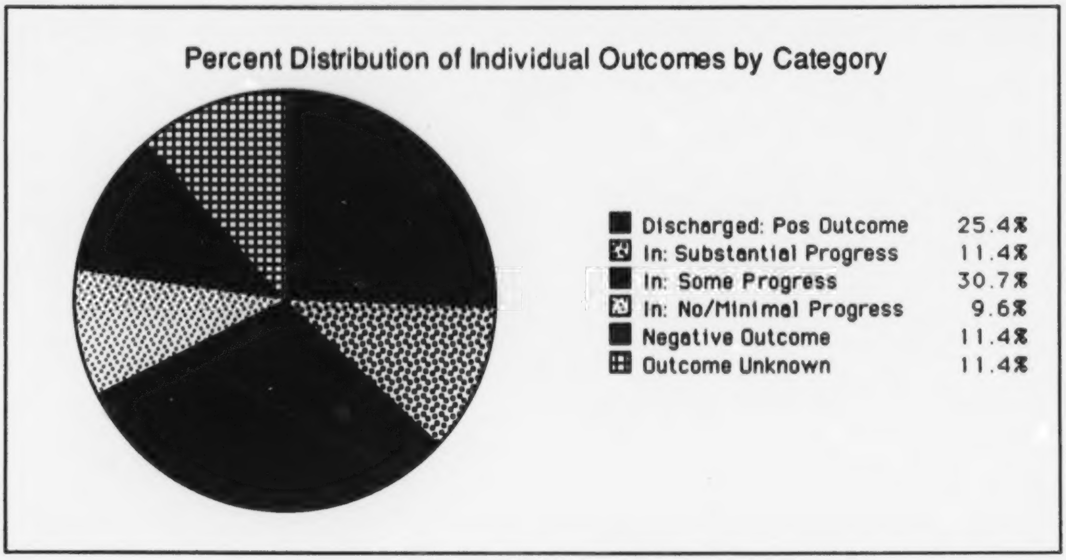
Individual Outcome Information

Individual outcomes for the 114 students in residential placement for educational purposes have been placed in the following categories.

1. Discharged: Positive Outcome: Student is discharged from facility and back in district, or in the community if aged out.
2. Still In: Substantial Progress
3. Still In: Some Progress
4. Still In: Minimal or No Progress
5. Negative Outcome: Student is no longer in placement for reasons including the following: ran away, parents removed against all advice, set fire and sent home, pregnant, left facility and now in juvenile court system, etc.
6. Outcome Unknown: Student is no longer in placement and follow-up information could not be obtained.

Outcome Summary

Summary outcome information, indicating percent distribution of individual outcomes by category is shown below. Outcome information by education region is also given.



Specific Outcomes By Region (R)

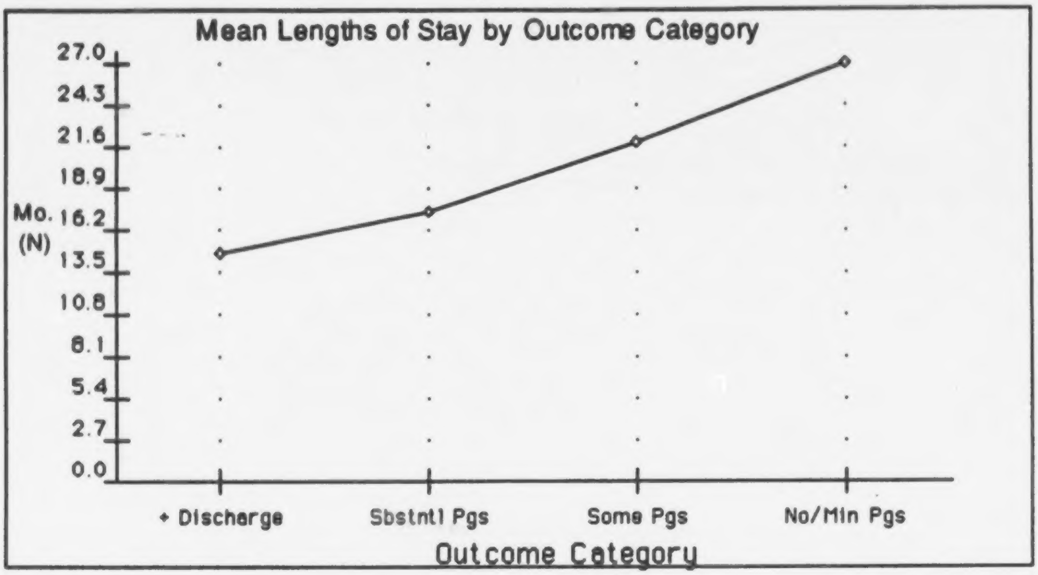
R	Discharged: + Outcome	In: Sbstntl Progress	In: Some Progress	In: Minimal No/ Progress	Negative Outcome	Outcome Unknown
1	1	1	0	0	0	1
2	0	0	0	0	0	1
3	0	1	0	0	1	0
4	8	1	5	2	2	1
5	1	0	0	0	0	0
6	3	4	7	0	2	5
7	1	0	0	1	1	0
9	0	0	0	0	1	0
10	0	0	1	1	2	0
11	2	0	2	1	0	0
12	1	0	1	0	1	0
13	6	3	15	5	2	4
14	0	0	0	0	1	0
15	0	1	0	0	0	0
16	0	1	0	0	0	0
17	4	0	1	0	0	0
20	2	1	3	1	0	1
	29	13	35	11	13	13

Outcome and Length of Stay

There is an association between outcome and length, or duration, of stay in a residential facility for ED students. Mean length of stay increases with less desirable or less positive outcome category.

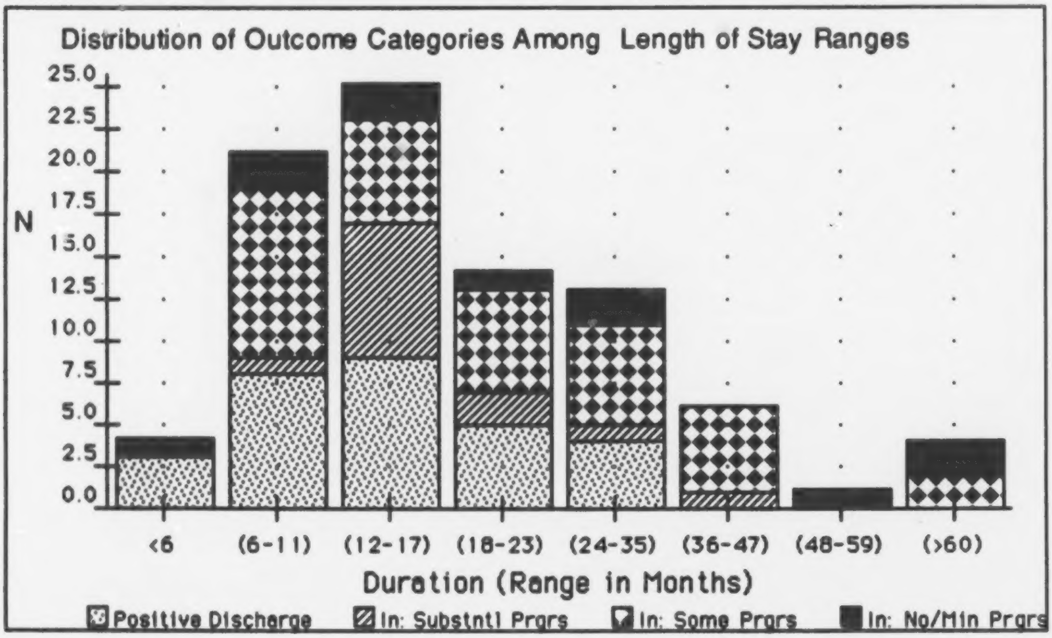
Summary Length of Stay Information By Outcome Category

Outcome	+ Discharge	Substantial Prgs	Some Prgs	No/Min Prgs	Negative	Unknown
N	29	13	35	11	13	13
Mean	15	17	22	27	36	27
Median	13	16	20	30	15/60	30
Range	3 to 24	10 to 38	6 to 60+	5 to 60+	8 to 60+	5 to 48+

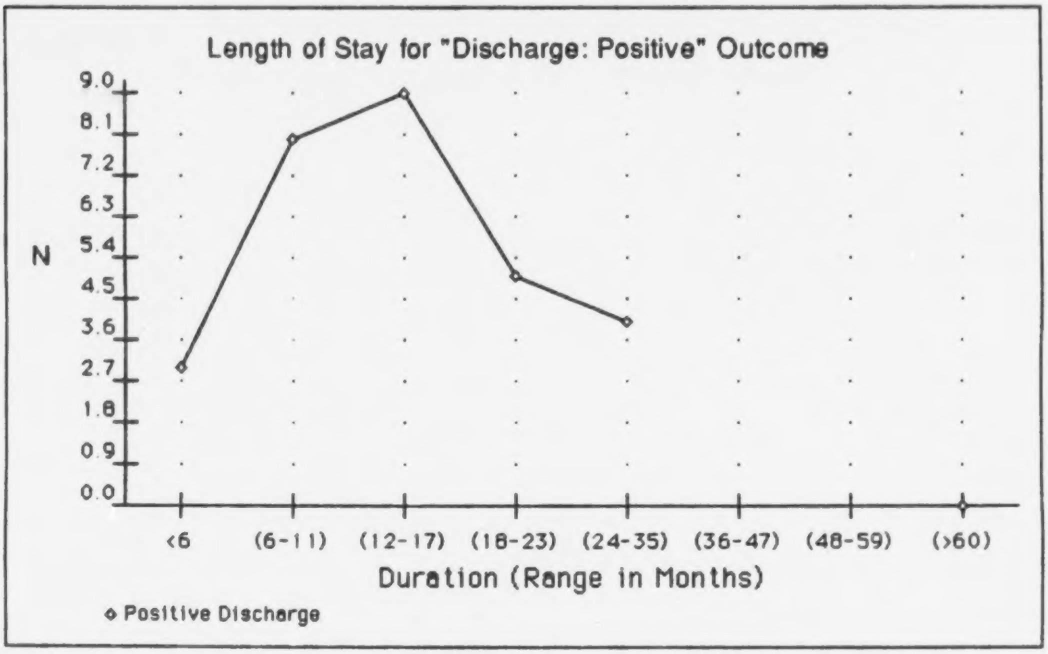


When the positive discharge category is compared to all "still in residence" categories (substantial, some, minimal/no progress), the mean length of stay for those discharged (15) is substantially less than for those still in residential placement (21.8).

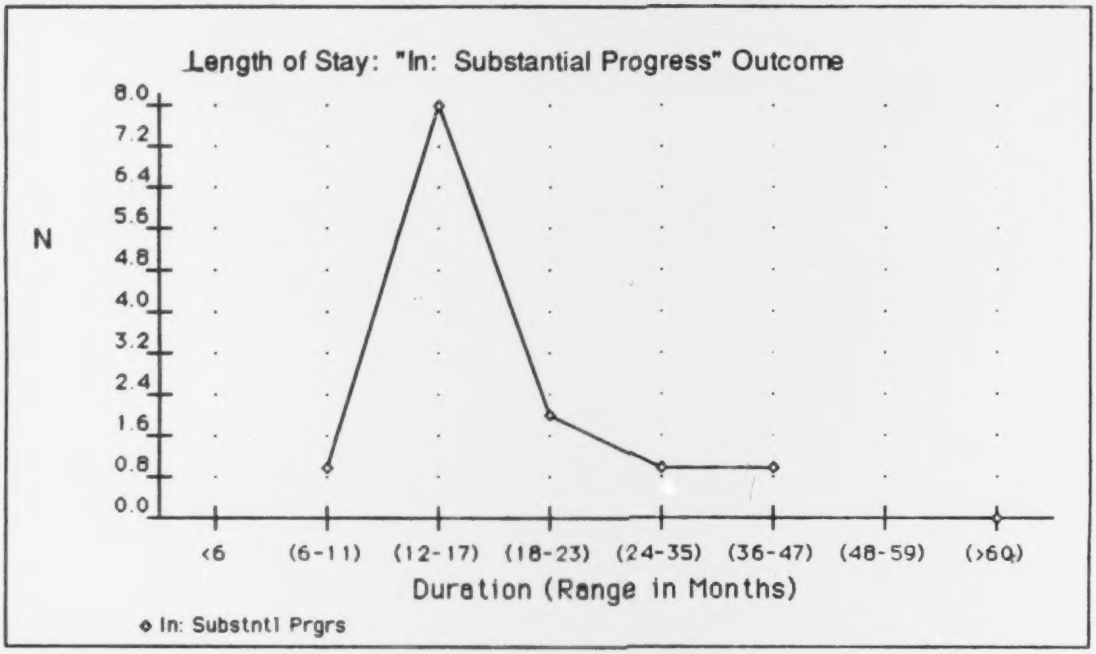
Although there is an apparent relationship between less positive outcome and longer length of stay, it should be noted that outcome categories are fairly well distributed throughout the ranges of length of stay as shown below (except for positive outcome).

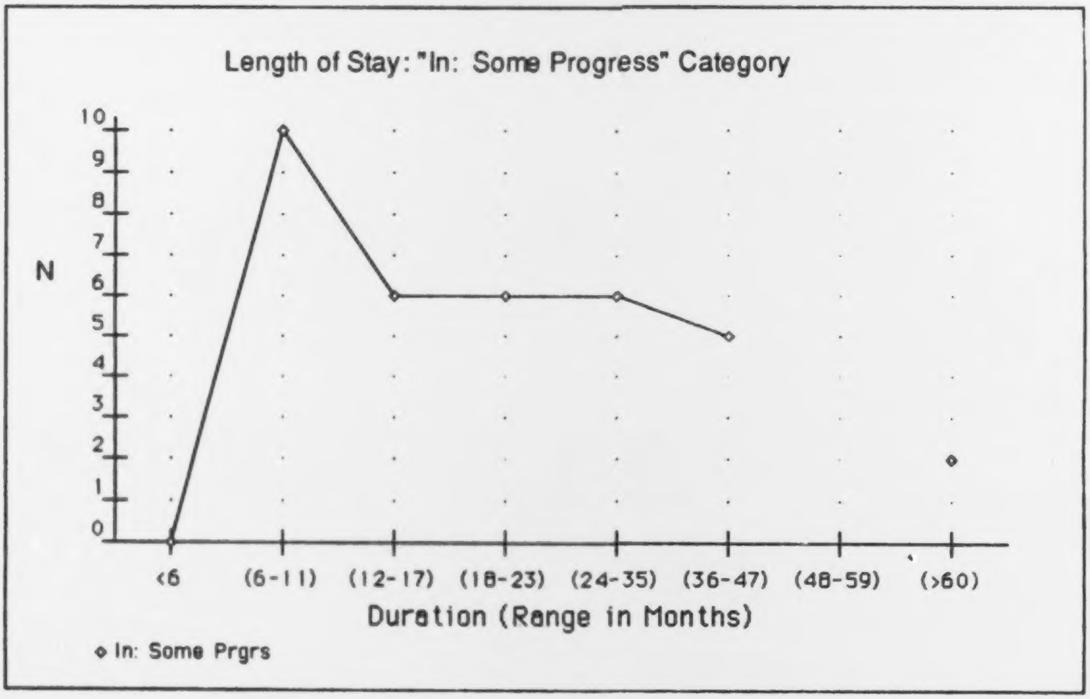


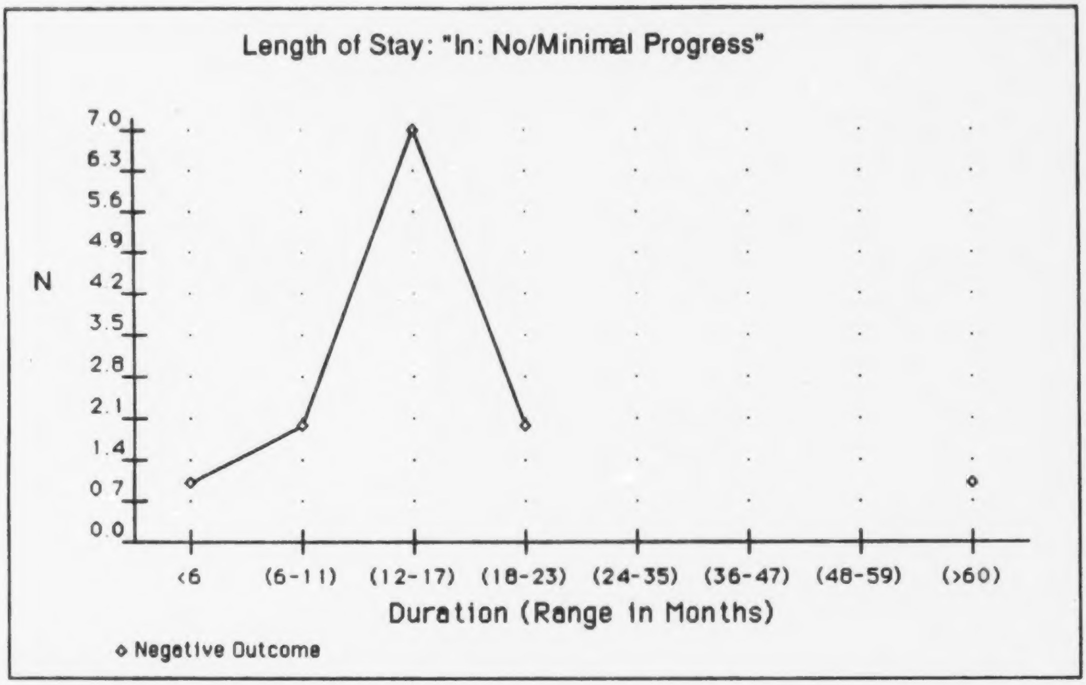
The "positive discharge" outcome, however, does bear a relationship to length of stay. If an ED student in residential placement is going to be discharged from residential placement with positive outcomes, it is likely to be within a short time frame.



The following figures depict the greater ranges of length of stay for the remaining outcome categories.







Outcome and Other Placement Variables

Outcome and Cost Per Month. There is no relationship between cost per month and outcome category. The different outcomes are fairly evenly distributed throughout the range of costs per month. (Refer to Table titled Cost Per Month for Each Residential Placement for Educational Purposes.)

Outcome and Age/Grade of Placement. There is no apparent relationship between age or grade at time of placement. Ages and grades represented among the outcome categories parallel ages and grades in the total N.

Likelihood of Returning to District (i.e. Positive Outcome) and Relationship to ADA. Students from larger distrticts are more likely to be discharged with positive outcome back into the district. There appears to be a greter likelihood of being positively discharged back into the distrct as ADA increases.

ADA	Likelihood of discharge
> 10,000	most likely to be discharged
500-999	↓
3000-10,000	
1000-2999	
< 500	least likely to be discharged

Outcome and Facility Choice

Conclusions cannot be drawn about the quality of facilities for the following reasons.

1. The small number of cases per facility available for analysis.
2. Residential placements for educational purposes may only represent a portion of each facility's clients.
3. Different facilities are geared towards different levels of behavior and degrees of difficulty, building in an inherent potential for differential positive outcome.

Reported Follow-Up for Positive Outcome*

Reporting of follow-up was disappointing in its brevity; however, the following was ascertained from survey responses.

Reported Follow-Up for Positive Discharge Outcomes

Some Follow-Up Reported:	**Frequency Cited:**	6
Very satisfied; facility continues to follow 18 mo later;	1	
Satisfied; appeared to be good; good; satisfied with ISD paying the bill	4	
Maintains contact	1	
No or Mimimal Follow-Up Reported:	**Frequency Cited:**	9
Not applicable	1	
Minimal due to distance/limited resources	1	
None requested	1	
No follow-up per parents insistence	1	
None provided; recommendation only sent with records	3	
No response	2	
Total number discharged with progress		15

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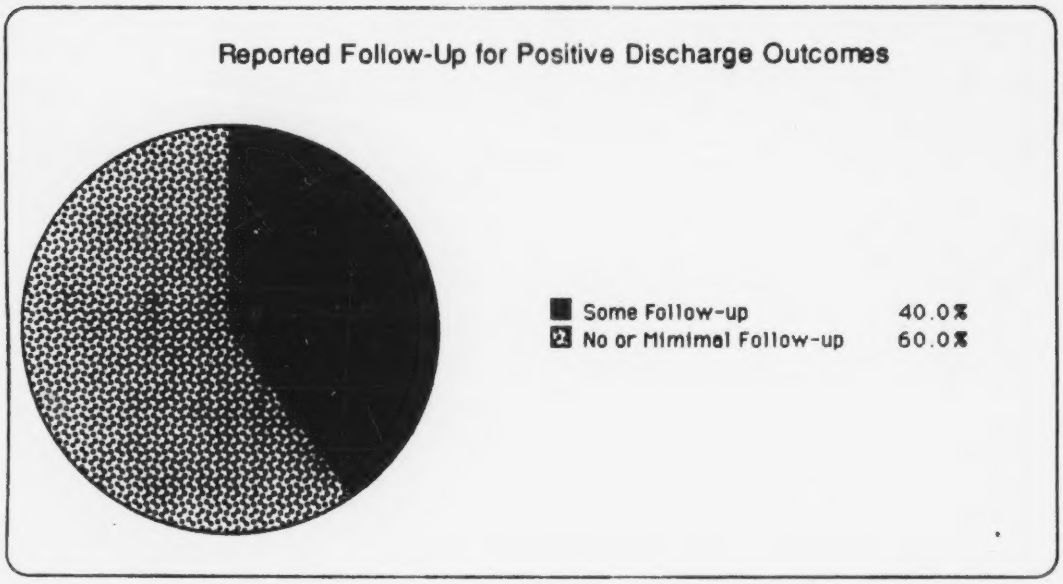
*Based on 86 survey responses (75% rate)



Reported Follow-Up for Positive Discharge Outcomes

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*Based on 86 survey responses (75% rate)

A COMPREHENSIVE SYSTEM OF CARE FOR CHILDREN AND YOUTH WITH EMOTIONAL DISTURBANCE

In 1984, based on findings by the Joint Commission on the Mental Health of Children (1969), the President's Commission and Mental Health (1978), and various other reports documenting the dearth of mental health services for children and youth in the U.S., the National Institute of Mental Health developed the Child and Adolescent Service System Program (CASSP). The function of CASSP was to support states in the development of interagency efforts to improve the system of care to children and youth with mental health needs. One of their primary tasks was to delineate the components of an ideal service system for children and youth with serious emotional disturbance.

The attached list of services is an abbreviated form of the CASSP document with some additions from other literature. This document is included as a possible planning document and as clarification of the many references in this report pertaining to "a continuum of services" or a "system of services" for children and youth with mental health needs. This list represents the ideal system of care for them. Progress toward this ideal is the immediate goal of this report. Other goals include the reduction of the number of institutional placements of Texas children and youth, the provision of quality mental health services, and the prevention of mental health problems in children and youth.

The recommended system of care (CASSP) is based on two core assumptions. These assumptions are that:

- the system of care must be child-centered, with services being driven by the child and family rather than by traditional agency configurations; and

- the system of care should be community-based, with services, management, and decision-making established at the community level.

Further guiding principles outlined by the CASSP and supported by the Joint Task Force include the following.

- The system of services should address a child's physical, emotional, social, and educational needs.

- The services should be individualized for each child/youth.

- The child should receive services in the least restrictive (most normalized) environment that is appropriate for that child.

- Families should be full participants in the planning and service delivery.

- The services should be integrated with coordination among service agencies in planning, service delivery, and program evaluation.

- Case management should be provided each child to assure integrated services.

- Early identification and intervention for children at risk for or having emotional problems should be promoted.

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- Transition to adult service systems should be facilitated as necessary.
- The rights of children and youth with emotional disturbance should be delineated and protected by effective advocacy efforts.
- Services should be provided without regard to race, religion, national origin, sex, physical disability, etc., and the system should be responsive to individual differences.
- There should be a balance of less restrictive and most restrictive services in terms of number and range.
- As many services as possible should be provided in or around the school in order to create a centralized location for mental health services.

The attached paper lists services based on eight basic areas. These areas somewhat correspond to existing agencies in Texas. These areas are:

- mental health services;
- social services;
- juvenile justice services;
- educational services;
- health services;
- vocational services;
- recreational services; and
- operational services;

CONTINUUM OF SERVICES TO CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE

Adapted from Stroul, B.A., & Friedman, R.M. (1986). A system of care for severely emotionally disturbed children and youth. Washington, DC: CASSP Technical Assistance Center.

Note: Services marked by an asterisk (*) are those that could potentially be housed within public schools or on public school grounds to make them more accessible and used more often by children/youth and their families. They may or may not be administered by or delivered by public school personnel.

I. Mental Health Services

A. Non-residential Services

*1. Prevention: Services delivered to individuals/families who have not yet been identified as having emotional problems, especially children at-risk genetically, prenatally, who are poor, etc.

a. Promote and train positive mental health and competencies (curricula and instruction).

b. Increase self-help groups and support systems.

c. Change system so that it is likely that children/families will be reinforced within the system.

d. Respond with support during stressful times (new in school, divorce, death of loved one, move to more restrictive setting, etc.)

e. Child enters mental health system if parent is receiving mental health services.

f. Case manager consults with significant people in child's life.

g. School-based coordination of and referral to various services for at-risk students.

*2. Early Identification and Intervention: Methods for identifying and intervening with an individual/family as early in the course of the problem as possible.

a. Health service personnel trained in infant mental health factors.

b. Professionals trust parent's perception of child's mental and physical health needs.

c. Birth-to-3 funds to include children at-risk prenatally and economically.

d. Identify children at risk of school failure and providing academic tutoring.

e. Training, counseling, support, linkage are either home-based, school-based, or combined (e.g., kindergarten, grade 1 and 2 teachers are trained to screen for adjustment problems. Children are then assigned to trained aides and provided 1-to-1, group, and family interventions).

f. "Homemaker" trained from the community to provide support and referral services to families.

*3. Assessment: A professional determination of the nature of an individual's or family's problems, the factors contributing to them, the assets and resources of the individual and family, and a recommendation for treatment and the nature of that treatment.

a. Use multi-disciplinary/multi-agency teams.

b. Assess health, psychological attributes, intelligence, academic achievement, social and behavioral functioning, family functioning, and child's environment.

c. Time the assessment to benefit the child. If in distress, initiate intervention and assess later. Get the child/family "hooked" into the system, then do assessment.

d. Don't over-assess. Use dollars for intervention and only use in-depth assessment for individuals who really need it.

e. Develop systems that avoid duplication of assessment procedures.

f. Use Family Systems assessment.

g. Include neuropsychiatric and neurophyschological assessments when necessary.

h. Assessment should lead directly to effective treatment, otherwise question assessment process.

*4. Outpatient Treatment: Daily, weekly visits by children/family to a mental health provider, usually in that provider's office/clinic for individual, group, or family therapy; medication prescription and review; parent training; social skills training; social support; problem-oriented counseling.

a. Family Skills Teams (Florida): Housed with dependency and delinquency intake staff. Provide 90-minute counseling sessions intensively and within 24-hour referral.

b. Mental health worker in schools provide on-site group/individual counseling, consultation with teachers, medication/behavior consultant, liaison with family.

*5. Home-Based Services: Crisis-oriented services to work intensely with children and families in their homes. A 24-hour service, with small caseloads, teams, family-focused, multifaceted interventions, services based on need, typically 2-5 months of service, follow-up assessment provided. Often called Family Preservation Programs.

*6. Day Treatment: An integrated set of education, counseling and family services, vocational training, crisis intervention, interpersonal and problem-solving skill-building, behavior modification, recreational therapy which involve an individual for at least five hours a day, usually for at least one year. Usually involves a collaboration of mental health and special education. Can be in regular school settings (Miami, FL), special schools (Rockville, MD), community health centers (Washington, DC), private/non-profit facilities (Cleveland, OH), or in hospitals. Can include day-treatment camps in the summer.

*7. Emergency Services: Continuum of services ranging from prevention efforts through crisis stabilization services in non-residential settings.

a. Training programs for crisis prevention and identification/ management for teachers, parents, police officers, and juvenile detention workers.

b. Crisis telephone lines - 24 hours a day.

c. Mobile crisis teams (New York) that respond to crisis on an outreach basis either in homes, schools, or retention centers.

d. Home-based counselor stays in the home for at least 24 hours during crisis.

B. Residential Services

1. Therapeutic foster care: Placement of child with foster parents who have been specifically recruited to work with children who are seriously emotionally disturbed. A case manager and training is provided. Foster families are part of a support system and receive a stipend. Can be administered by various agencies and multiagency funded.

examples:

. Professional Parenting Program (North Carolina) provides $400 above regular stipend for specialized care.

. PRYDE (Pittsburgh) and Mentor Program (Boston) uses foster parents more as employees, who use certain techniques, and receive $600-$1200 above regular foster families.

2. Therapeutic group care: Provision of a therapeutic environment and program for individuals who are seriously emotionally disturbed in homes serving from 5-10 individuals with a variety of therapeutic interventions (usually derived from social work or social-psychological origins). These are usually not court dependent children. This is usually a single home located in a residential community. Sometimes serves the delinquent population returning to the community.

   example: . Teaching Family Model (University of Kansas; Boys Town, Omaha) uses trained staff, structured behavioral interventions, and teaches new, improved behaviors.

3. Therapeutic Camp Services: Children/youth who are seriously emotionally disturbed and staff live together in a wilderness situation. Emphasis is placed on interdependence and basic survival. Group process is stressed. It sometimes includes family therapy and special education. Often used for juvenile delinquents.

   examples: . Eckerd Camps (Florida and North Carolina)
   . Outward Bound (headquarters in Pennsylvania)

4. Independent Living Services: Preparation to live independently and for paid employment. Includes special education transition programs, vocational rehabilitation programs, and job training programs. Can include therapeutic group home designated for older adolescents.

   examples: . Daily supervised apartment living
   . Partially supervised apartment living
   . City Lights (Washington, DC)

5. Residential Treatment Services: Provision of a round-the-clock treatment and care to children/youth usually licensed by the state. These are usually campuses with at least one secure unit for crisis situations. Includes own educational system, central location for eating and recreation; very self-contained; trained staff; therapeutic milieu.

   examples: . Project Re-ed (Whitaker School, NC)
   . Devereaux Foundation Programs
   . Brown Schools
   . Waco Center for Youth

6. Crisis Residential Services: Promote rapid restabilization and return to the home and community. They provide residential placement during acute crises; short-term; intensive treatment; attempt to avert hospitalization; community-based.

   a. Crisis home--provides care in homes of trained lay persons. Could be therapeutic foster parents or therapeutic group homes linked with psychiatric care.

   b. Short-term crisis residential--2-4 week stay in a facility (24-hour) that is not a hospital (e.g., Transitional Residence Independence Service, Stratford, NJ).

   c. 24-hour acute/intensive services provided by psychiatric hospitals.

7. Inpatient Hospitalization: Treatment for extreme situations for youngsters who are showing serious acute disturbances or perplexing and difficult ongoing problems. Usually not placed with adults; may have specialized units; very restrictive.

   a. Emergency placement--crisis stabilization for a few weeks.
   b. Comprehensive evaluation--30 days.
   c. Long-term treatment.
   d. State hospitals.
   e. Private psychiatric hospitals.

II. Social Services

A. Supportive

*1. Protective Services: Services designed to prevent neglect, abuse, and exploitation of children by reaching out with social services to stabilize family life. Usually follows a complaint or referral. Includes supervision, assistance, referrals, removal of child from the home.

B. Supplementary

*1. Financial Assistance: Financial relief to families with no fathers (primarily) so that children can remain in the family and thrive. Inconsistency among states in eligibility.

*2. Home Aid Services: Services to strengthen the family by providing assistance in the home, usually by nonprofessionals. Can be done on an emergency basis.

   a. Homemaker services: assistance with housekeeping and childcare (The Vermont Wraparound project trained community women to make referrals, assist with transportation, advise on prenatal care).

b. Caretaker: If parent is absent (planned or unplanned), an adult stays in the home. Can prevent the removal of children.

c. Parent aide services: Planned service of a trained nonprofessional to work on an ongoing basis with an abusive, or potentially abusive parent. Becomes a partner for the parent. Usually a volunteer.

d. Family preservation services: Intensive assistance, therapy, assessment, referrals, etc., to keep the family functioning and intact. May be part of mental health services or social services. Available on an emergency basis. Takes the service continuum to the family when needed.

e. Respite care: Planned break for the parents (biological or foster) who are caring for a difficult child. Can be babysitting, center activities, or weekend respite.

C. Substitute Services

1. Shelter Services: Provision of a temporary placement, typically for no more than a few days at a time. Usually used when a child is awaiting foster placement and has been removed from the home or in between foster placements. Should include counseling and be short-term.

   a. Juvenile detention: One type of placement (locked) for children/youth who have committed an offense.

2. Foster Care: Placement of children in foster family homes, group homes, group child care facilities and residential treatment centers. The children have usually been removed from homes due to abuse, neglect, or abandonment and have either been adjudicated "dependent" by the courts or voluntarily placed by their families. (502,000 in the U.S.) Public Law 96-272 (1980) Adoption Assistance and Child Welfare Act provided incentives for states to maintain children in own families, and subsidies for adoption of disabled children.

   a. Therapeutic foster care: usually provided by mental health agencies.

3. Adoption: Permanent placement of children with a family. Return to the biological parents is unlikely. Training, support, and subsidies are necessary for the adoption of special needs children.

III. Juvenile Justice Services

A. Pre-adjudication

1. Detention: Similar to foster care, but a locked facility to hold the child/youth until legal action can be taken regarding the offense committed.

example: . Sex Offender Group is run by the mental health agency in Ventura County for adjudicated sex offenders and their families in the detention facility.

. Classrooms provided in detention facilities.

B. Post-adjudication

*1. Probation: Child/youth stays in the family or current placement with the regular supervision of a probation officer. Certain restrictive criteria must be met depending upon the judgment, including attendance at special counseling sessions, or placement in particular classrooms.

2. Correctional Facility: A 24-hour highly supervised and restrictive living arrangement primarily for the purpose of punishment for a crime, but also for the rehabilitation of the child/youth. Some are locked, some are not. Educational and therapeutic services are often provided. Children and youth are usually not placed in the adult correctional system.

3. Transitional Group Home: Similar to therapeutic group homes run by the mental health agency with the purpose of integrating the child/youth back into the community/family after time spent in a correctional facility. Youth usually attend the public schools.

IV. Educational Services

A. Regular Education

*1. Prevention: Efforts within the schools to prevent the onset of emotional disturbance.

a. Regular education screening: Screening by all personnel for signs of students at risk for various problems (i.e., child abuse, truancy, drugs, failure in school, health disorders).

b. Student assistance teams: A group of professionals assigned to assess at risk students, assist with problem solving, provide referrals for various services, and coordinate these services.

c. Preschool programs: Special school programs for preschool children who are genetically at-risk, developmentally delayed, who live in poverty, etc., emphasizing language development, self-concept development, and social skills.

d. Social skills instruction and empathy training: Instruction given to all school children to master interpersonal skills, problem-solving and decision-making strategies, and explore cultural values and moral decision-making.

e. Schools of Tomorrow and Communities in Schools: In-school coordination and provision of community services for at-risk children/youth.

*2. Alternative Programs: Programs designed for students, not labeled for special education, but who, usually for behavioral reasons, need something different than the regular classroom. These may be founded on alternative educational theories and could have interagency services, such as drug education. They tend to accommodate those students at risk of dropping out of school or those who have already dropped out (e.g., evening high school).

B. Special Education

*1. Assessment and Planning: Multidisciplinary assessment to determine special education eligibility and individualized planning for educational programs in the least restrictive environment. Includes similar assessment package to the mental health assessment with more emphasis on school performance.

*2. Liaison Teachers: Teachers (not assigned to classrooms) acting as case managers to students who are seriously emotionally disturbed by coordinating services outside the school with the teacher, the family, and the child/youth (e.g., Positive Education Program in Cleveland based on a Re-Ed model).

*3. Consultant Teacher: The student remains in the regular classroom with consultant services from a special education teacher for adaptation of materials, planning, remedial instruction to the student, etc. Student is seldom pulled out of the regular classroom.

*4. Resource Rooms: Student spends up to three hours in a special education classroom with a lower student-teacher ratio in order to receive assistance (with academics primarily).

*5. Self-Contained Classroom: Full-day structured classroom with low student-teacher ratio and emphasis on behavior and social skills.

a. Special Day Class (mental health/special education): A type of day treatment often with education/mental health collaboration. The classroom can be in a public school or another facility. Added to the self-contained classroom is intensive group and individual counseling usually provided by mental health personnel.

*6. Special Schools: The entire school is designed to serve students with disabilities. No students without handicaps attend the school. It is usually highly structured with low student-teacher ratio. It is often used as a step toward residential placement or a step out of residential placement. Usually run by the local education agency.

*7. Home-Bound Instruction: Educational services delivered up to five hours a week in the student's home by a special education teacher. This should be a short-term interim placement.

*8. Residential Schools: A 24-hour living/school arrangement usually with counseling and other services available. These are intensive treatment centers, but not hospitals. These are basically the same as the residential treatment centers described under mental health services, and can be non-profit or profit-making facilities.

9. Hospital Classes: Classrooms housed in psychiatric hospitals to provide as much school as possible for the patient. They are usually staffed by a certified special education teacher. The classroom is usually part of the therapeutic milieu and emphasis tends to be on clinical rather than educational intervention.

*10. Transition Planning and Intervention: Educational plans and programs directly addressing the movement of the student from school to the world of work. These plans are usually developed in conjunction with the rehabilitation agency and the program may consist of interpersonal skills training, job training, basic skills development, community awareness, etc. (See vocational services)

V. Health Services

A. Prevention

*1. Health Education and Prevention: Education through the schools, youth organizations, family, and TV emphasizing methods of maintaining good physical and mental well-being. Needs to include the family, especially pregnant women.

*2. Screening and Assessment: Services designed to promote early identification of potential health problems.

a. Early Periodic Screening and Diagnostic Testing for preschool, low-income children.

b. Mandated vision/hearing screening and immunizations for school registration.

c. School-based health clinics: Collaborative effort between school and health department to provide education, screening, and primary care services in school to youth.

B. Direct Care

*1. Primary Care: Comprehensive health examinations by physicians at regular time periods during the critical developmental period. Includes follow-up care for identified health problems. Also includes dental, vision, and hearing care. Might also include reproductive health services, treatment of sexually transmitted diseases, treatment of alcohol/drug abuse, and eating disorders.

2. Acute Care: Medical services provided to children/youth who are injured or become seriously ill. These might be inpatient or outpatient. Might include detoxification programs. These are usually provided by regular health care personnel.

3. Long-Term Care: Services provided to chronically ill children/youth and their families, usually to prevent extreme stress or emotional trauma. These services might include counseling and education as well as medical treatment.

VI. Vocational Services

A. Prevocational

*1. Career Education: Curricula that lay important attitudinal and knowledge base for subsequent vocational training. Includes awareness of types of jobs and how to choose one. Usually starts in elementary school.

*2. Vocational Assessment: Systematic process for determining an individual's aptitudes, interests, level of functioning and readiness for employment. Includes formal and informal methods. The goal is to match an individual with a vocation for which he/she is suited. Also includes assessment for "job readiness."

*3. Job Survival Skills Training: Training in interpersonal relationships, social skills, community survival skills. Can be trained by school personnel, rehabilitation personnel, or mental health workers.

B. Vocational

*1. Vocational Skills Training: Direct training in the technical aspects of particular jobs. This is usually provided through vocational education programs in the schools. Can be provided in residential treatment centers or special schools.

*2. Work Experiences: Actual work experience either in simulated "shops" or supervised placements. Can also be part-time and temporary competitive employment.

*3. Job Finding, Placement, and Retention Services: Services to help youth to locate job opportunities, successfully apply for jobs, and to retain employment over time. Might include teaching job-seeking and interviewing skills or providing direct assistance in identifying, obtaining, and keeping jobs. Includes summer job programs.

4. Sheltered Employment: Employment in settings with high levels of support and supervision. Can be used as training or transition sites.

VII. Recreational Services

*1. Relationships with Significant Others: Matching a child/youth who needs adult companionship with a committed adult for recreational activities. Usually the adult is a volunteer.

examples: . Big Brothers/Big Sisters
. Mentor programs

*2. After-School Programs: Recreational programs for children of working parents or for at-risk students. Can include tutoring and social skills training during recreational activities. Often might be a collaboration between schools and city recreation departments and/or therapeutic recreation specialists. Can also be special programs for children/youth with serious emotional disturbance.

*3. Summer Camps: More intense therapeutic recreation experience. Can be residential or day camps. Provides respite for parents. Might be operated by residential treatment facilities, universities, mental health agencies, or charitable organizations.

*4. Special Education Recreational Projects: Projects usually sponsored by service organizations to help problem children/youth (e.g., therapeutic horseback riding).

VIII. Operational Services

*1. Case Management: Brokering services for individual children/youth, advocating on their behalf, ensuring that an adequate treatment plan is developed and implemented, reviewing client progress and coordinating services. It involves aggressive outreach to the child and family, working with them, community agencies, and resources to ensure that all needed services and supports are in place.

*2. Self-Help and Support Groups: Individuals and families who have a history of problems are grouped with others who have similar problems for the purpose of support and the learning of coping strategies.

examples:
- . Alcoholics Anonymous
- . National Alliance for the Mentally Ill
- . National Mental Health Consumers Association
- . Parents Anonymous

*3. Advocacy: Efforts to improve the quality of services and strengthen the rights and protections accorded to children.

a. Case advocacy: advocacy on behalf of the needs of individual children. Can be the case manager, lawyer, etc.

b. Class advocacy: advocacy on behalf of a group of individuals. Usually carried out by consumer groups and professional organizations.

*4. Transportation: One of the major problems in providing services to children and youth. Need to improve the accessibility of services to children/youth and families. Bring services to home, set up satellite offices, establish more school-based services.

*5. Legal Services: Process of ensuring that the child/youth's rights are protected, legal advocacy, developing relevant statutes, and insuring that adequate services are available. Also includes the juvenile justice system.

a. Court liaison with schools: Representative of the school or the court is assigned the liaison function of coordinating information, programming, etc., for adjudicated youth.

b. Support for transition from placement (transition classroom): Special classrooms/programs for adjudicated youth in receiving educational services.

*6. Volunteer Programs: Volunteers can provide direct services, raise funds, provide transportation, assist with data collection and clerical tasks, organize activities, or identify resources.

a. Parent Aide Program: Community volunteer to assist abusive or potentially abusive parents.

Assumptions About the Continuum

1. The services are community-based.
2. There is interagency coordination and cooperation.
3. Services are culturally sensitive.
4. It serves the most disturbed children and youth.
5. Services are driven by the child/family--not a specific agency.
6. Children's mental health problems and system are separated from adult's.
7. There is a balance of less restrictive and most restrictive services in terms of number and range.

Goals for all Agencies

1. Reduce the number of institutional placements.
2. Expand the range and number of community-based services.
3. Provide quality services.
4. Prevent mental health problems in children and youth.

CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM (CASSP) SURVEY OF COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS

During the summer and fall of 1989, staff members of the Child and Adolescent Service System Program (CASSP) conducted a Key Informant Survey. The director and two regional coordinators interviewed key personnel from community mental health centers (CMHCs), state hospital community service programs, and state centers about issues related to mental health services for children and adolescents. Staff from the community providers included various personnel, including executive directors, mental health directors, and directors of children's services.

The survey was conducted to initiate contact between community providers and CASSP staff for planning, implementation, and evaluation activities during the following three years. It was not within the scope of the survey to include statistical information, but rather to establish a baseline of information about what exists.

Thirty-six interviews were conducted, and included staff from 27 CMHCs, five state hospital community programs, one state center program, and three in-patient psychiatric units associated with state hospitals.

It is acknowledged by the Texas Department of Mental Health and Mental Retardation that public mental health services for the 0-18 population are lacking in Texas. Until recently, there has not been an emphasis on child/adolescent mental health. While this has been the result of a lawsuit-directed adult treatment system taking priority over other services, it is not inconsistent with the lack of services nationwide for this population.

During the past two decades, there has been a massive shift in the mental health system from institutional to community care for adult clients. While this rapid evolution has taken the attention, energy, and resources of the limited public monies, the child/adolescent mental health picture has been ignored. This has occurred nationwide.

In 1984, the National Institute of Mental Health, through the Child and Adolescent Service System Program, began to focus attention on the lack of community mental health services for the young. Since that time, the program has provided limited funds to states for planning and evaluating a coordinated system of care for the severely emotionally disturbed population of children.

This system has an underpinning of interagency coordination, family involvement, client-centered least restrictive care. Systematic coordinated research is beginning for the first time on what works in treatment, the nature of the illness, financing, and planning/implementation issues.

This survey was conducted to provide both information for the Texas CASSP, and to establish a presence for the program in the state.

Assessment and Referral

Discussion of these state-operated facilities is essential when discussing assessment and referral. As with adult services in the past, many community children/adolescent services are related to the state hospitals. In the majority, if not all community mental health locations, a child or adolescent requiring treatment in a state hospital has access to that referral process, and some type of follow-up upon discharge. The quality and quantity of the follow-up will depend on the site. The most seriously disturbed children and adolescents are treated in the state hospital child and adolescent units, and those under contract. Since this is the only service in many locations, those inpatient beds tend to be over-utilized.

Inpatient services for adolescents are available at five state hospitals, while three of the institutions have children's units. In addition, two of the state hospitals have contracts for children's services with a private psychiatric hospital. Waco Center for Youth is a 72-bed psychiatric facility for longer term treatment which serves children statewide. Daybreak Children's Hospital services children and adolescents for a portion of East Texas not served by a state hospital. Vernon Center South, part of Vernon State Hospital, is an adolescent inpatient facility for the treatment of substance abuse.

Waco Center for Youth referrals were listed by 12 of the sites as being a major referral source, while Vernon South was listed by only two of the respondents. This is a reflection of the reduced role of mental health centers in the treatment of substance abuse problems in the community, and the view of Vernon South as a facility primarily for the juvenile justice population.

A majority of the sites reported referrals to local counseling centers, such as Child Guidance Centers, or other sliding-scale services. This indicates the need for counseling in the communities as well as the lack of those services at the local Texas Department of Mental Health and Mental Retardation sites.

Referrals from the centers are also routinely made to the state hospitals, private psychiatrists, and residential facilities, as well as to Texas Department of Human Services, schools, and youth shelters.

Referrals into the System

Of the 36 sites surveyed, 25 reported DHS as a major referral source into the system, as well as schools and the juvenile justice system. This is consistent with national trends, which identify those children/adolescents who are involved in other systems at-risk for emotional disturbance. In the schools, these children are often identified as special education emotionally disturbed, or at least displaying behavior/emotional problems which set them apart. Other referral sources into the community system include private providers, physicians, churches, parents, courts, general hospitals, and state hospitals. Of interest is that one-third of the informants identified private providers as a major referral source, generally being inpatient units which discharge patients to the public sector when funds have been exhausted.

Most of the centers reported no waiting period for services, while six reported waiting periods as long as four weeks. All reported no waiting period for emergencies.

Available Services

The variability in the type and amount of services for children and adolescents around the state is significant. Some of the larger urban CMHCs have a range of services available to at least a portion of the population, while others have no identified treatment services at all. Following is a representative sample of the services as identified during the key informant survey. These numbers are taken from the 33 administrative entities which provide community services. The numbers are not actual service sites. That number is much larger.

. 51% of the informants reported outpatient counseling was available for children and adolescents. Often this counseling, as all services offered to this population, is provided by generalist practitioners who also treat adults.

. 66% of the informants reported that medication monitoring is available at this time.

. 6% of the CMHCs reported having day treatment programs.

. 27% of the informants reported having case management for children.

. 66% of the sites reported having family therapy services. This is related to the availability of family support services which are generally available for adult patients.

. 24% of the informants reported having substance abuse services available.

There are obvious caveats to these figures. Initially, the question to the informants was open-ended, asking that services be enumerated. Second, there were no definitions for the services offered. However, the figures are useful in examining the general lack of services, and the variability across the state. Citizens in some localities can expect a certain level of services from the local public mental health mental retardation entity, while those in others have no expectations.

Staff

Of the community programs reporting, Harris County reported having more than 50 staff members providing only children and adolescent services. Nine (21%) reported having one to four staff serving just children and adolescents. Four (12%) reported having 5-9 staff, as did a like number reporting 9-14. The remaining categories were represented as follows: 15-19, one site; 20-24, one site; 35-39, one site. The largest category represented those sites having no identified child/adolescent workers. Ten (30%) reported having no specialists who worked with children exclusively. Work with children and adolescents goes on in these centers, but is performed by generalist practitioners. This has no reflection on the quality of work, but does indicate that almost a third of the sites surveyed have no identified child/adolescent administrative entity.

Interagency Coordination

Sixteen of the informants (44%) reported having formal interagency contracts, or contracts for services in their communities. Often these consist of contracts to provide services to schools, such as with the Department of Human Services, for specific purposes or populations, such as assessments for special education, or sexual abuse counseling. Twenty-one (63%) reported informal coordination, such as interagency councils or regular meetings on an informal basis.

Needs Identified by Informants

The informants identified the following needs as the first or second priority.

Crisis Stabilization	41%
Additional Staff	38%
Residential Beds	33%
Day Treatment	22%
Respite Care	16%
Case Management	11%

(Other needs, all below 10%, included group homes, counseling, child psychiatrists, training, and substance abuse treatment.)

Again, this was an open-ended question asking the informant to name, in priority, the most pressing needs in the community. The need for short-term crisis stabilization beds was listed by almost half of the informants, while additional staff was another obvious high priority. Several of the informants referred to the need for a comprehensive continuum of care in the community, as well as for badly needed discrete services.

ADMINISTRATORS' SURVEY FOR THE TASK FORCE ON EMOTIONAL DISTURBANCE

In the spring semester of the 1989-1990 school year, the Joint Task Force on Emotional Disturbance conducted a written survey of 358 public school special education directors in Texas to determine their perceptions of (1) current availability of services for students with emotional disturbance, (2) the charges of the Joint Task Force, and (3) cogent recommendations for the task force. The directors surveyed are special education program administrators in either single member districts or in special education cooperatives comprised of two or more local education agencies (LEAs).

Twenty education service centers (ESCs) operate in Texas to provide intermediary educational services to local school districts. The location of the regional ESC office is shown in Table 1 and in Table 3 of this report. The 171 directors responding to the survey (47 percent of those surveyed) are representative of each of the 20 ESC areas as shown in Table 1.

As required by the Education for All Handicapped Children Act, the number of special education students served in the nation is reported annually to the Congress of the United States. This child count is taken on December 1 of each year. Additionally, in Texas, a comprehensive Superintendent's Annual Report is forwarded at the conclusion of the school year to the Texas Education Agency. One item of information in the Superintendent's Annual Report is the number of special education students served by the LEA during the given school year.

The surveyed directors were asked to approximate the number of special education students reported in the December 1, 1989, child count, as well as the number of special education students reported in the 1988-89 Superintendent's Annual Report to the Texas Education Agency. The total number of students reported by responding directors is given in Table 1 per regional ESC area.

In Table 1, the total December 1 child count is given as approximated by the 171 directors responding to the administrators' survey. Additionally, the reported cumulative enrollment of students in special education programs is given for the 1988-89 school year.

A copy of the "Administrators Survey for ED Task Force" instrument and accompanying letter of instruction are included at the conclusion of this report.

Table 1: Frequency of Administrators (N=171) Responding per ESC and Number of Special Education Students Served

	Responding Special Education Directors		No. Special Education Students	
ESC Region Office	Single ISD	Cooperative	Dec 1 '89 Count	Supt Report
I -Edinburg	2	1	1,687	1,999
II -Corpus Christi	3	4	3,444	4,214
III -Victoria	4	5	4,887	5,533
IV -Houston	27	2	54,518	65,074
V -Beaumont	3	1	1,574	1,779
VI -Huntsville	5	6	5,813	6,597
VII -Kilgore	5	7	5,435	6,174
VIII -Mount Pleasant	0	3	1,703	1,566
IX -Wichita Falls	3	2	4,747	6,249
X -Richardson	9	4	23,210	32,779
XI -Fort Worth	12	9	22,543	26,925
XII -Waco	6	2	3,939	7,232
XIII -Austin	2	5	4,747	5,512
XIV -Abilene	1	2	1,421	1,303
XV -San Angelo	1	2	1,221	1,487
XVI -Amarillo	2	6	3,288	3,544
XVII -Lubbock	1	7	5,863	7,131
XVIII-Midland	3	3	2,214	2,558
XIX -El Paso	1	0	4,436	6,179
20 -San Antonio	5	2	13,896	15,803
ESC Region Not Identified	2	2	2,251	2,512
Totals	96 (56%)	75 (44%)	171,616	212,150

In Table 2, the frequency distribution is given for 5 ranges of December 1 enrollment (child count). In the 171 special education programs represented in the administrators' survey, the largest enrollment of special education students was reported by Houston ISD (18,600), and the least enrollment was reported by Austwell-Tivoli ISD (8).

Table 2: Range of Students Enrolled in Special Education Reported on the December 1, 1989 Child Count

No. Students	District or Cooperative	Percent
1-499	61	36%
500-999	69	41%
1000-1999	21	12%
2000-4999	14	8%
5000-20000	4	2%
Not Reported	2	1%
Total	171	100%

Residential Placements

In the Administrators' Survey, special education directors were also asked to "approximate the number of seriously emotionally disturbed (SED) students whose parents reside in the district/cooperative and who are now in a residential placement (regardless of their entrance status, i.e., placed by parents, other agency, or school)." The task force recognized that, especially for urban school systems, this number would be particularly difficult to ascertain.

The special education directors surveyed were also asked to specify the "number of students with SED residentially placed by the school district or cooperative at the present time." The number of reported residential placements is shown in Table 3 of this report. Not responding to the survey or reporting data were Alief ISD (Region IV) with six residential placements made in the 1989-90 school year at Behavior Training Research, Inc., in Manvel, Texas; Round Rock ISD (Region XIII) with 11 residential placements in the 1988-89 school year; or Conroe ISD (Region VI) with 20 residential placements in the 1988-89 school year.

For purposes of the survey, no distinction was made in placements for students with emotional disturbance or students with emotional disturbance and other disabilities, i.e., mental retardation.

Table 3: **Frequency of Students with Serious Emotional Disturbance in Residential Placement**

ESC Region Office	Approximation	District Placed
I -Edinburg	0	0
II -Corpus Christi	21	1 (TSD)
III -Victoria	3	2
IV -Houston	473	5
V -Beaumont	0	0
VI -Huntsville	19	10
VII -Kilgore	6	0
VIII -Mount Pleasant	0	0
IX -Wichita Falls	1	0
X -Richardson	837	6
XI -Fort Worth	302	2
XII -Waco	216	2
XIII -Austin	28	7
XIV -Abilene	13	1
XV -San Angelo	1	0
XVI -Amarillo	6	4
XVII -Lubbock	43	1
XVIII-Midland	4	0
XIX -El Paso	0	0
20 -San Antonio	17	7
ESC region not identified	6	1
Total	1,996	49

TSD—Texas School for the Deaf. It is not known if this student is also SED.

Community-Based Networks of Outpatient Services

Respondents to the Administrators' Survey for ED Task Force were asked to "describe the community-based networks of outpatient services" which are currently available in your area for students who are emotionally disturbed who would otherwise be placed in a residential placement." Eighty-two of the respondents (49 percent) indicated that no such network exists in the areas they serve. Thirty-seven of the responding directors (22 percent) reported that the MHA (or MHMR) served as the community-based network for their districts or cooperatives. However, some of these reports seemed to reflect the "right answer" type of response. Later disclosure revealed concerns about these services. For example, while TDMHMR was given as a description of the "community-based networks of outpatient services" currently available in Polk County Special Services, the director later noted, "We virtually have no community-based networks, support, and/or services."

The Dallas Independent School District and Dallas County MHMR have obtained one of four major state grants recently awarded. A public school liaison will be funded and a day treatment program will be developed in a school with the grant funds.

Another 22 respondents (13 percent) stressed that local MHMR services were, in their perceptions, limited in these respects.

Number of responses:

8	MHA assistance minimal to non-existent
3	only suicidal or homicidal or only severe cases accepted
4	distance/transportation to MHMR services prohibitive to families
2	difficulties with interagency cooperation
3	services not available for ages 3-22
2	long waiting lists and waiting times for families
1	inconsistent service delivery by MHA

Six directors described school services as the only available "community-based networks of outpatient services." Another 22 special education administrators noted that private psychiatric hospitals or private therapists are available as networks or that they provide after-care. Several comments were made concerning the expense of private hospital placements. Additionally, one director noted, "Many therapists in our area have a "connection" with psychiatric hospitals. We feel that students are hospitalized many times without real justification--just because insurance is available. Hospitals from 135 miles away have marketing people in our area."

In three ESC areas, no services were reported. These regions are located in areas which include the service center office in El Paso, Wichita Falls, and San Angelo. Other responses of the survey are summarized according to the regional ESC area of the reporting administrator.

Region I - Edinburg

South Texas Independent School District - Edinburg Campus, 8-12 grades

Tropical Texas Center for Mental Health and Mental Retardation (Edinburg) currently has individual and family counseling on a sliding fee scale.

Region II - Corpus Christi

TDMHMR facility in Alice concentrates efforts upon services for youth and adults who are emotionally disturbed.

TDMHMR - Rockport

MH - only for children who are homicidal or suicidal

Region III - Victoria

TDMHMR Center (50 miles away) for monthly counseling and medication checks

MH-MR and Family Outreach Program

Matagorda County Cooperative reported, "The services in our area are limited. The mental health clinic refuses some students and are inconsistent about seeing those that are scheduled to be seen. There is a counselor coming weekly on a trial basis to our community, who is targeting at-risk and potential drop-out students. Some of those referred have been students who are emotionally disturbed."

Riceland Mental Health Center & Riceland Regional Youth Services provides counseling in the county and crises facilities by doctor referral in Wharton.

Lutheran church counseling service

Gulf Bend Mental Health and Mental Retardation Center, Phoenix Center, Live Oak Treatment Hospital

Region IV - Houston

Riceland Mental Health Authority

STAY-IN Home Therapy Program, private/non-profit

Networks with Ft. Bend Regional Alcohol/Drug Abuse Council & Juvenile Probation

Local mental health and mental retardation agency (Galveston) offers some programs and family services. Primarily the only program used is a daytime ranch which provides structured compliance training.

TDMHMR, Family Service Center, Child Guidance, Chicano Family Service Center, University of Texas Mental Science Institute (Houston)

United Way Agency (Youth Services) in Brazosport

Family Interventions (Barbers Hill ISD)

University of Texas Medical Branch outpatient services in Galveston

Tri-County Mental Health and Mental Retardation (Liberty County)

Day treatment services are available in local psychiatric facilities; Family Service Center has treatment/counseling for parent consideration in Fort Bend County.

Basically, only private therapists for outpatient counseling and therapy through TDMHMR (20 miles away)

Region VI - Huntsville

TDMHMR

Tri-County Psychiatric Services

Montgomery County Youth Services

Family Time Counseling

Region VII - Huntsville

Work with Pinelands Hospital (Nacogdoches)

Mental health and mental retardation counselor only; psychiatrist sees clients only to dispense medication

Absolutely no assistance from Texas Department of Mental Health and Mental Retardation (TDMHMR), Department of Human Services (DHS), Texas Youth Commission (TYC) and very limited from Texas Rehabilitation Commission (TRC).

Region VIII - Mt. Pleasant

MHA - Terrell State Hospital Outreach

Region X - Richardson

MHMR Children First: Free counseling provided in-home to families of students who are emotionally disturbed; Fourth Street Project offers a variety of counseling services to students who are emotionally disturbed and their parents (Grand Prairie)

Private counseling and Metrocrest Youth and Family Services for first offender adolescents (Carrollton-Farmers Branch)

Dallas County MHMR operates an afternoon program which provides ongoing therapy and family support for at-risk students.

Salesmanship Club

Emergency shelters

Tough Love and support groups

Region XI - Fort Worth

All the treatment centers provide counseling to schools.

Mental Health local facility (Crowley)

Tarrant County MHMR provides limited assistance and so does Child Study Center. Child Study Center has many more referrals than they can serve.

Lena Pope Home provides outpatient services.

Parenting Guidance Clinic

Several hospitals have partial-day programs.

Mental Health/Mental Retardation Services of Texoma

Wise County Transition Center provides life skills training, social adjustment, recreation/leisure skills, job training, job development and job placement.

Life Center, a day treatment facility (expensive)

Charter Dallas/Fort Worth outpatient clinic (expensive)

Family counseling through TDMHMR and local psychologists

Psychiatric Institute of Granbury

Region XII - Waco

Terrell State Hospital (Terrell)

Willowbrook Hospital (Waxahachie)

TDMHMR (Waco) and Waco Center for Youth (Waco)

One MHMR counselor in county (Bosque); position is currently vacant

Region XIII - Austin

TDMHMR, "but not much happens" (Bastrop Special Education Cooperative)

Mental health office for severe cases (East Williamson County)

Wilderness group counseling (East Williamson County)

Core services, workshop, respite care, counseling (Giddings Cooperative)

Region XIV - Abilene

Charter Plains Counseling Center

TDMHMR counseling services (understaffed in Taylor/Callahan)

Region XVI - Amarillo

Short term facilities: Cedar Creek Hospital and Quest Outpatient Services (Amarillo); Safe Place (Canyon)

Excellent services through PIA Hospital, Northwest Texas Hospital-Adolescent Care Unit, St. Anthony's Hospital - Quest Unit, for those who can afford or have insurance

TDMHMR limited services (Pampa)

MHMR group and individual counseling

Mental health facility (Hereford Coop) provides outpatient services

Region XVII - Lubbock

MHMR psychiatric consultation and limited counseling program

MHMR services if student is eligible under mental health criteria

Region XVIII - Midland

MHMR counseling (Ft. Stockton)

Mental health patient-child counseling (Pecos-Barstow-Toyah)

TDMHMR (Kermit-Wink-Loving)

Region 20 - San Antonio

Residential facilities provide outpatient services (Judson).

TDMHMR provides some services.

Mental health clinic at Kerrville State Hospital Outreach

There is a county-wide referral group, but no other networks as such. (Balcones Cooperative)

Individual services are available such as:
- after-care at psychiatric hospitals;
- private services such as counselors, psychologists and psychiatrists; and
- contract services with individual therapists or community agencies.

In their descriptions of available services, special education administrators frequently mentioned lengthy waits for these services. For example, the special education director of Garland ISD noted that counseling and outreach services were available through TDMHMR, "but there is a lengthy wait of 3-4 months for intake."

One cooperative program (Collin County) noted that through a noneducational community-based services grant, they are able to provide the following services for 11 designated students who are seriously emotionally disturbed: individual family therapy, case management, respite, psychiatric consultation, before/after school care, and home training.

In Region XI, one special education director noted that no services were available through state agencies. "This is the Dallas/Fort Worth area, so there is a wide array of expensive outpatient services. There are almost none for families without insurance. Two United Way agencies provide counseling, but have long waiting lists."

Table 4 presents a summary of the responses of special education administrators to their descriptions of "community-based networks of outpatient services" which are currently available in their areas for students who are emotionally disturbed who would otherwise be placed in a residential placement.

Table 4: Frequency of Special Education Administrator Responses (N=171) Describing Area "Community-Based Networks of Outpatient Services"

Response		Frequency	Percent
No Network Exists		82	48
TDMHMR Provides		36	21
Limited TDMHMR Services		26	15
Only Private Psychiatric		21	12
Only School Services		6	4
	Total	171	100

Interagency Agreements

The directors surveyed were asked to designate whether their local school district or cooperative had entered into any interagency agreements with the area or county TDMHMR. Of the 171 respondents, 140 (82 percent) indicated that no interagency agreement had been established between the school and local or area mental health agencies. The administrator of one district noted, however, that an agreement was "in the process."

On a somewhat more positive note, 26 surveyed administrators responded that interagency agreements had been developed and described these arrangements:

- At Victoria Public Schools, a job training interagency agreement had been developed, "...but has not worked well."
- Jackson County Co-op (Region III) described an agreement to serve those students referred to them by the cooperative.
- Lamar Consolidated (Region IV) reported an informal agreement with TDMHMR and with over eight other agencies in a Community Resource Group. Another district in Region IV reported entering 3 agreements with TDMHMR. Of these, the district paid for residential placement with EHA-B set-aside money. "We do not plan to enter any other agreements." Also in the Region IV ESC area, the local districts of Galveston/Brazoria County entered into an interagency agreement with TDMHMR to provide a day school program to which the local districts can contract to send students. Ft. Bend ISD noted, "At parent option, Family Service Center and local psychiatric hospitals may be used."
- One single-member district and one cooperative in Region VI noted that an interagency agreement was established "for residential placements" and "TDMHMR will provide respite care on a very limited basis." Another district in Region VI also reported positively that an agreement had been developed, but did not describe that arrangement.

- In Region VII, one director affirmed, "Our cooperative has two students who are employed at the local MHMR workshop. Our school pays a fee of $250 per month per student." In that same ESC area, a county-wide cooperative program director noted, "We do not have a county MHMR unit."

- In Region X, two agreements were in progress in a single member district (Duncanville) for requesting (a) social interaction training for an autistic student, and (b) attendant care, self-help skills training, family therapy, and respite care to return a residentially placed student to the district. Another district in Region X responded that a one page, very general agreement was in place with a scheduled revision due. Still another district described the interagency agreement with TDMHMR to be related to five students with mental retardation rather than emotional disturbance.

- In Region XI, a single-member district (Crowley) noted that TDMHMR and the school have an agreement to provide an alternative placement for students with severe behavior disorders. Another single member district in Region XI (Alvarado) reported that an interagency agreement was in place, and, "We try to meet several times a year with a representative from each of the school districts in our county and TDMHMR people."

- Hood-Somervell Special Education Cooperative reported positively, "TDMHMR and the school work well together at this point. We contract with them for services and they attend admission, review, and dismissal meetings." Similarly, Johnson County Special Education Cooperative reported an interagency agreement described as, "We have contracted for vocational training for MHMR students through mental health programs."

- Other interagency agreements described in Region XI include one with TDMHMR and TRC for transition services and two aborted attempts between a school district and mental health at Wichita Falls State Hospital. "They are not coordinating services with us. They say their philosophy is different from other agencies." In the other unsuccessful undertaking, the director (Cooke County Cooperative) stated that, "TDMHMR recently advised us they are discontinuing our contract with them for next school year because they are going to concentrate more on their adult mental health clients."

- In Region XIII, Manor ISD reported an interagency agreement for one student placed in a community-based noneducational day program; TDMHMR gives support with counseling and respite care. In the Bastrop Special Education Cooperative, TDMHMR provides services to parents of "residential students"; Giddings Cooperative noted "individual contracts with member districts."

- An interagency agreement was entered into by Dumas ISD and TDMHMR in behalf of one residentially placed student. Lubbock ISD (Region XVII) reportedly completed an agreement.

- At Ft. Stockton ISD (Region XVIII), the interagency agreement stipulates that TDMHMR will provide counseling regularly to the families of students who are emotionally disturbed and TDMHMR has, in the past, arranged for residential placement (at their expense). For a cooperative special education program in Region XVIII, TDMHMR provides a local unit and an interagency agreement is in place.

- Finally, an agreement between the Cluster VII Cooperative in Region 20 and TDMHMR provides for after school care/instruction, weekend (respite) care, and assistance/training for parents.

One district special education director stated that, while written interagency agreements had not been developed, less formal efforts were in place such as a joint community resource group meeting monthly (Matagorda County). Another referred to residential placement interagency agreements, while the director at McLennan County Department of Education stipulated that Waco Center for Youth contracts with TDMHMR.

The reporting administrator in Houston ISD responded that, while no formal agreement was currently in place, several were pending. Other directors implied that the newly regulated individualized transition plan (ITP) process may result in increased or expanded LEA/TDMHMR written agreements.

Dallas ISD recently received one of the four major MHMR state grants which will result in an interagency agreement between the school district and the Dallas County MHMR.

Family-Centered Response and Intervention System

The surveyed special education directors were asked to denote the availability in their communities of "a family-centered response and intervention system for students with emotional disabilities and their families." Negative responses numbered 126 (74 percent of respondents).

The affirmative responses included five "yes" with no further comments or clarifications. Additional responses are summarized as follows:

11	MHMR (Rockport, Liberty-Eylau, Greenville, Dallas County Suburban Cooperative, Lancaster, Crowley, Alvarado, Hood-Somerville Coop, Johnson County Southeast Coop, Corsicana, Caprock)
3	Family Outreach Program
3	only through private psychiatric hospitals
1	in Victoria, 30 miles away
1	Riceland Mental Health Center
1	Family Service Center (and local psychiatric hospital)
1	Dallas County MHMR has a crisis hot line
1	Plano Child Guidance, Family Guidance and City House
1	Parenting Guidance Center & Child Study Center (Fort Worth)
1	Friends of the Family for spouse/child abuse cases (Cooke Co.)
1	Wichita Falls State Hospital twice monthly
1	Charter Plains Counseling Center
1	Family counseling program available in the community (NW TX Co-op)

From Houston ISD, the district responding with the greatest special education enrollment, these agencies were noted: (1) Shape Community Center, (2) Chicano Family Center, (3) Association for the Advancement of Mexican Americans, (4) Family Service Center, (5) Child Guidance, (6) TDMHMR. Another single-member district in the Region IV area listed these agencies: Family Outreach, Houston Child Guidance, United Way, and Family Service Center. The Liberty County Cooperative for Special Education, also in the Region IV ESC area, detailed Family Outreach Center and Family Service Center.

Mention was also made of services consisting of "only an outreach center from Wichita Falls State Hospital (counseling)." The response from Grand Prairie ISD stipulated, "The various residential centers will come to the school campuses and work with students and parents. We, as a district, also offer parenting classes for parents of SED students. Free family counseling is also offered through the district."

Similarly, Dallas ISD supports counseling from Southwest Family Institute for in-home family counseling. This school district also has crisis psychologists who work with students who are emotionally disturbed and their families.

One director summarized, "The underlying cause of virtually all requests for residential services is that there are not community agencies that address the need for counseling and therapeutic services for the emotionally disturbed."

Recommendations for the Joint Task Force

Those directors surveyed were given an opportunity to provide optional comments and/or recommendations for the task force. Their comments are categorized according to the prevalent themes or issues given in Table 5.

Table 5: Comments and Recommendations Identified by Special Education Directors (N=171)

Issue	No. Comments
Interagency Considerations	28
Disability Identification	16
Staff Development	16
Funding	13
Parental Involvement	6
Placement Options	4
Memorandum of Understanding (MOU)	3

The comments which follow are quoted directly from the survey responses.

Interagency Considerations

Try to get these other agencies to accept more responsibility and to be held accountable for their responsibilities. The burden, as always, is on the school, and we have to fight for any little service that we get.

There are SED students desperately needing help that schools are not equipped or funded to meet their total needs. TDMHMR is the agency that should be providing care, but they are doing absolutely nothing.

If possible, develop a system to encourage (or require) local mental health authorities to serve these students and their families.

School districts must have help from other agencies to address the critical issue of serving students with emotional disabilities. This assistance affects all of our society tremendously.

I am concerned about the lack of transitional services post-high school.

MHA needs to increase services for children and adolescents.

TDMHMR and DHS should assist in providing home training and after school care or assistance in the home. These agencies may help further by providing semi-independent facilities.

Make a statement that schools cannot provide all of the services to SED or at-risk students. Family services are the responsibility of the MHA.

Little assistance is provided by TDMHMR outside of larger cities.

Too many agencies promote their services when the public school is really the best place for the child. Also, much of the time the parent is the one in need of help!

Necessity for networking to access these services for students in rural communities.

Parents and families need assistance when they are in crisis. It is not always a school problem. They also need ongoing, extensive, and intensive therapy that can be supported by the community.

Need community resources, family training, and a network of "ED hotlines" where youngsters could call to get help at any time.

Pressure TDMHMR to recognize that children and youth do exist.

Rural areas have practically no community mental health services. Rural areas are in desperate need for help for SED children. Outreach services for rural communities are recommended.

We need more residential treatment centers that are not private entities.

Establish weekend respite care facilities.

The state hospitals should be used for residential treatment for SED students.

Facilitate TDMHMR's provision of parent counseling--especially for students/families with problems of alcoholism, drug or physical abuse.

More services need to be available through TDMHMR for outpatient services for families of SED students.

TDMHMR needs to expand its services. TDMHMR and DHS need to be more involved. Especially in the valley, TDMHMR needs to be involved and engaged.

Cooperation between school and community services will require an organizational structure and leadership with authority. Hopefully this is forthcoming.

Disability Identification

Students are under-identified because of cost.

Try to get attention deficit disorder (ADD) removed from public school ED criteria. One consideration that should be addressed at the state level is the removal of ADD from SED criteria for public schools. Clearer and more precise understanding between psychologists and educators on ADD is critical.

Allow SED to be diagnosed by associate school psychologist without psychologist supervision.

We need professionals who are familiar with Texas Education Agency requirements for SED and who can distinguish between behavior disorder and SED for staff and provide appropriate recommendations for both school and home setting.

More explicit guidelines for ED diagnosis are needed. Help with definition and clarification of definitions (of handicaps). What some psychologists consider SED is not SED by other psychologists.

We must identify as early as possible.

The clarification regarding social adjustment difficulties versus emotional disturbance has been most helpful to school districts. Efforts to educate or disseminate this information to other agencies would be helpful--TDMHMR, DHS, etc.

Clearly define SED versus social maladjustment and determine ways to distinguish between SED and social maladjustment. Continue to delineate and clarify between SED and socially maladjusted.

Continue to work to clarify the differences between conduct disorder and SED.

Staff Development

Sponsor realistic, down-to-earth workshops for regular and special education teachers. More training is needed for special education teachers concerning how to cope with SED students.

The dissemination of "Best Practices" would be helpful.

More teacher training (for SED) and certification programs are needed.

We need assistance with related services. It is difficult for small districts to provide family services or even counseling for the SED student.

We need good, qualified teachers.

The task force could help the schools to apply for and obtain noneducational support project money from Texas Education Agency.

Attention needs to be focused on conduct disorders and how these students operate in programs for emotionally disturbed.

Keep us informed.

Provide information about useful and practical instructional arrangements for emotionally disturbed, especially in light of the fact that this population is growing.

More training is needed for teachers--regular and special education.

Submit results of findings to directors and implications/recommendations based upon these findings.

Campaign to win acceptance for students who get better to be accepted by peers and teachers.

Training and curriculum materials are needed for preventive social skills training for all special education students.

Training and procedures are needed for those dealing with identified SED students.

Funding

Non-educational funds (TEA) recipient guidelines must be expanded--NOT tied to just those students at-risk for residential placement.

Prevention and intervention strategies with MONEY!!

Many people are turned away because they cannot pay the fee charged--nor do they have insurance. Local MHAs claim they must charge but that they tell people that no one will be turned away because of nonpayment. However, the families who return to the school after their visits never seem to understand this. They come back saying "We can't afford to go."

Encourage TEA to help local districts through more funding for help with SED students and their families. Change funding weight for SED students so that it is higher.

Need for state funding for mental health to help fund services for day programs where education would be provided by the school, but TDMHMR would provide psychological services, therapy, or other services that would treat the emotional disturbance.

Funding must be provided for services if they are mandated.

Develop alternatives for residential care that can be implemented by the districts and recommend funding to go with the implementation.

School districts need access to funds for short-term intervention treatment.

Recommend a higher pay scale for teachers of students who are seriously emotionally disturbed.

We have a great need for more money for programs for these students, particularly for (1) elementary school counselors, and (2) funds for interagency cooperation.

Encourage continuance of non-educational community-based support funds from Texas Education Agency.

Parental Involvement

Parents need to be encouraged to attend parenting classes before or during their child's placement in a self-contained setting.

Establish parenting skills and support groups.

We need family involvement. Help us help the parents.

We desperately need a family-oriented service to work with families; this should be the responsibility of the mental health department (TDMHMR).

Focus on prevention! It's our only hope.

Placement Options

We need alternatives to place the hard to manage, aggressive, SED student.

Give recommendations to set up networks in local communities to serve SED students.

Need residential facility or centralized treatment center for Abilene area to meet needs of SED students and parents in this area.

Ideas are needed for rural areas with very limited resources and low incidence populations to serve.

Memorandum of Understanding (MOU)

In the MOU, the responsibilities for schools have been outlined and mandated regardless of the availability of staff. This is not the case with MHMR. These students and their families need their services, too.

MOAs and MOUs are great ideas on paper, but hard to get local people to cooperate. We (schools) seem to be the only folks with funding, and we don't have enough to meet our needs.

TDMHMR must agree with other agencies on transitioning students into community settings and help share the responsibility.

Summary

The 171 administrators of special education programs who responded to the "Administrators Survey for ED Task Force" represent each of the 20 regional education service centers in Texas. Fifty-six percent are directors of single-member district programs and 44 percent represent special education cooperatives.

Respondents report that only 48 students qualifying as emotionally disturbed had been residentially placed by admission, review, and dismissal committees serving the LEAs in which they administered programs with nearly 200,000 special education students in the 1988-89 school year. No school district responding to the survey had placed more than two emotionally disturbed in residential placement. However, one single-member suburban school district which did not respond to the survey placed five emotionally disturbed students in residential settings during the 1989-90 school year, even though the same resources were available to that district as were available to similar districts in the Region IV ESC area. One recommendation would be to investigate the factors which contribute to the disproportionate need for residential placements in this or similar districts.

Almost half of the directors surveyed indicated that no "community-based networks of outpatient services" existed in the areas in which they administer special education programs. Over 80 percent noted that no interagency agreements had been established between the LEA and local or area mental health agencies. Likewise, over 70 percent of the respondents acknowledged that no "family-centered response and intervention system" was available for students with emotional disabilities and their families.

The overall focus of comments centered on special education directors' perceptions that schools "are not getting much help from the outside" for children with emotional disabilities and that ancillary services are often nonexistent. Further, they relate limited access for families to services as well as perceived lack of accountability on the part of other agencies. An evident need is for guidance from the TEA and MHA regarding establishment of interagency agreements with the goal of alleviating these expressed concerns.

FAMILY TREATMENT MODELS AND SCHOOL INVOLVEMENT

Involvement of families of children with emotional disabilities is imperative if schools are to meet the educational and treatment needs of these children. Traditionally, treatment approaches have focused upon individualized methodologies that focus services upon the particular child with an emotional disorder. Therapeutic gains can be easily offset when the family is not also involved in looking at the needs of the child. An ecological approach has been suggested by the report of the Joint Task Force, and in the current applied psychology literature, that dictates that 11 constituent elements and systems of a child's functioning be perceived within an ecological-systematic framework. The following discussions will help the reader to understand the theoretical frames of family functioning and treatment perspectives.

There are numerous models of family treatment. Those that are reviewed in the following sections represent several theoretical perspectives. The models themselves include Minuchin's structural theory, Watzlawick, Weakland and Fisch (1974), Satir, Haley, and Selvini. All of these models see the purpose of therapy as one of changing the family's interactional style and thus breaking the cycle of negative behavior within the system and in the members. This type of work is seen by the task force as sometimes necessary to help ease the pressures on the child and to mobilize the family to work with other systems on behalf of the members (children) as well as enabling the family to respond more effectively with other systems, such as the school.

Minuchin's structural approach emphasizes the role relationships of family members and how each person's behavior pattern affects every other member's routine. The family's dysfunction is seen as its inability to accept the changing status of children as they enter adolescence and its attempt to force their divergent behavior back to what was acceptable when they were younger. Consequently, the family becomes consumed with trying to hold on too tightly to young people who are very naturally trying to define themselves as independent (Minuchin, 1981). Therapeutic intervention consists of establishing what a family's overall pattern of involvement with each other is and then helping them establish less rigidly controlling or interlocking patterns of behavior.

Much of Minuchin's approach to therapy developed during his tenure at the Philadelphia Child Guidance Clinic, and involved working with a significant number of lower economic group and minority families. He stated that supporting the parent(s) and reinforcing their role as the person(s) in charge was critical to joining with the family and getting them to commit to therapy.

Strategic theorists like Waltzlawick, Weakland and Fisch (1974) see the same general framework of rule-governed behavior patterns in families. However, strategists see the parents' efforts at setting rigid limits amplifying the adolescents' rebellion which increases the effort at control and rebellion in an ever increasing cycle (Watzlawick et al., 1974). The treatment goal is to break this escalating cycle. The therapeutic process does not depend on the participation of the whole family as in the structural approach, but based on working with the most motivated members of the system to break the negative cycle of escalation. Therefore, the therapist must establish a clear alliance with the person or persons seeking change in the family and encourage them to persevere in the process of change, expecting resistance from those not participating in the therapy.

Jay Haley (1980) follows this same line of reasoning, arguing that parents stay over-involved and overly responsible for their adult children's behavior. Unlike some other therapists, he believes client families want a highly directive counselor who will make strongly prescriptive behavioral corrections to the clients' present responses. His goal is to give the family some concrete set of behaviors in exchange for the unproductive routines they hope to eliminate in therapy. Rather than take the role of nurturer and letting the family discover the answers to their dilemma, Haley firmly believes in taking charge and telling people what to do. He believes clients are seeking action more than insight when they enter therapy.

Virginia Satir sees the family's purpose as one of enhancing self-esteem; this allows people to be mature or rather be in the process of maturation (Okum & Rappaport, 1980). This maturation process allows people to form a differentiated self in which there is a healthy sense of uniqueness within the family system. She theorizes that trouble comes when this process is interrupted. Satir sees the therapist's role as one of helping each member of the client family see and accept the uniqueness of every other member as a positive aspect of healthy family life. This acceptance is enacted by the therapist first, who finds some meaningful and healthful contribution from each member to the family as a whole. After the contribution is found and acknowledged, counter-productive behaviors can be addressed and modified.

While to Satir individuals and families are innately good, for Murray Bowen they are not. He see families as a necessary but potentially destructive system, with a tendency to swallow up individuality (Foley, 1974). Individuals must learn how to respond, rather than react, to the system. Bowen works toward this goal by inserting himself into the dialogue of family members, a process called detriangulation. From this vantage point, each statement and response is mediated through the therapist with the goal of clarifying the communication process. The therapist facilitates family change by not falling prey to the unhealthy statements that cause pathology in the family. To be effective, the therapist must be perceived as an honest broker willing to speak for all members equally.

Selvini and the Milan group explicitly acknowledge to the client family that the therapist becomes involved in the relationships and may lose perspective on the circularity of the system, how symptoms tie in with other family members behavior. Consequently, a team of fellow therapists is on the other side of a one-way mirror or partition and will call in on a telephone with questions or observations for the attending therapist to relay into the session. It is possible for only one therapist to ask these questions and elicit the difference between the family members which would open the family system to intensive self-scrutiny necessary to develop interventions, or even better, for the family to make changes on its own (Tomm, 1984). However, the team makes the related processes of hypothesizing and maintaining neutrality less contingent on a single therapist's skills. The therapist present in the room can either present the idea as an observation they have made or ascribe it to the team. In this manner, the level of support and conflict between clients and therapist can always be fine-tuned to maximum therapeutic effect.

SURVEY OF PARENTS WITH CHILDREN WITH EMOTIONAL DISTURBANCE

To obtain vital input from parents of children with emotional disturbance, the Task Force on Emotional Disturbance distributed a data collection instrument through the 20 regional education service centers. The instrument was designed by the Task Force, with input from the Texas Alliance for the Mentally Ill; a copy is attached in the appendix.

Response Characteristics

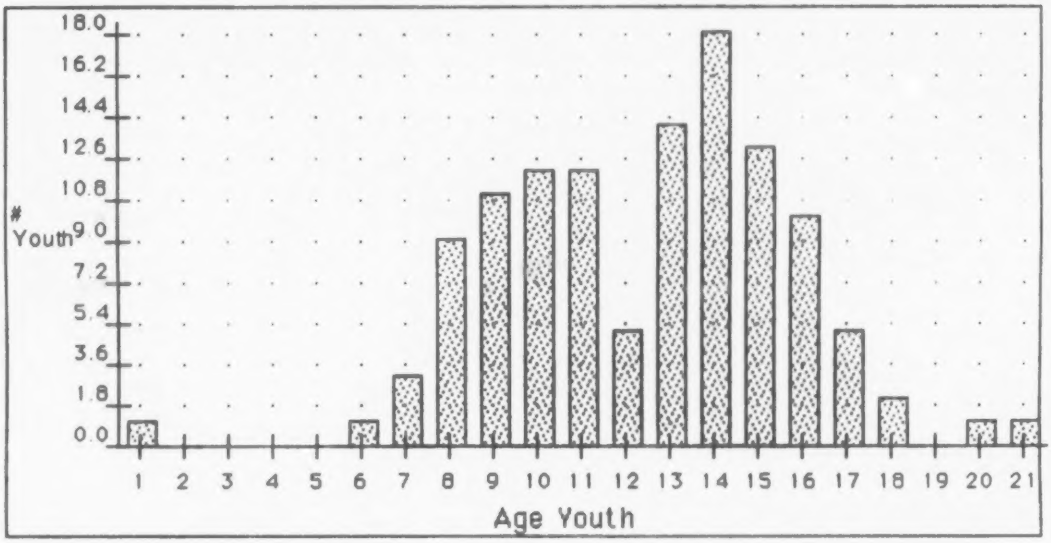
As of September 5, 1990, 120 parents, parent couples or adults legally responsible for a child with emotional disturbance returned completed surveys. Respondents represent 13 out of 20 regions, and 23 counties.

Respondent Information

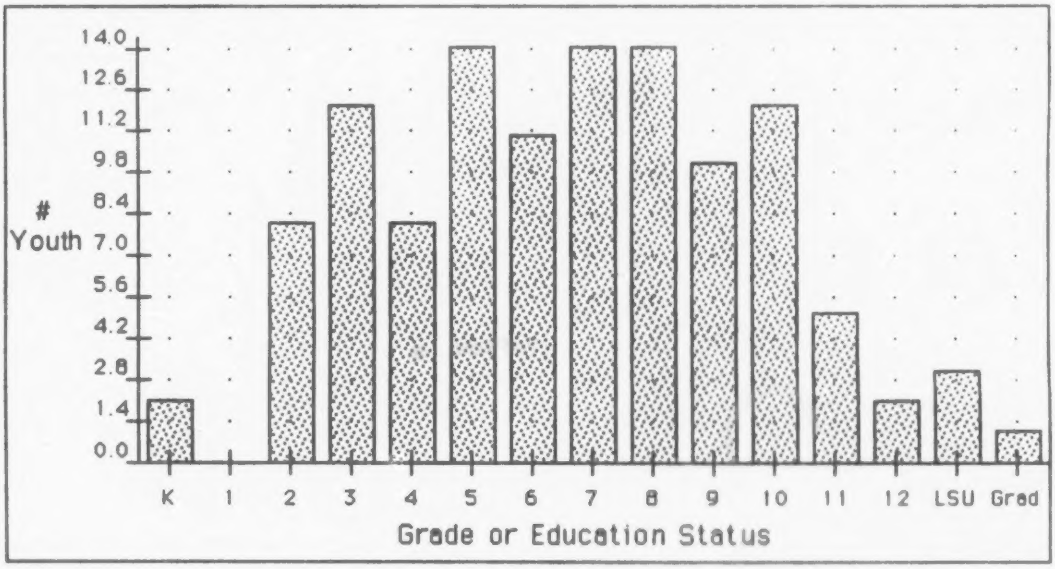
County(23)	Rgn (13)	N
Bexar	20	6
Brown	15	2
Cameron	1	1
Collin	10	2
Colorado	3	4
Dallas	10	4
El Paso	19	4
Ft. Bend	4	11
Freestone	12	1
Galveston	4	13
Hardin	5	1
Harris	4	31
Houston	6	4
Montg'ry	6	9
Orange	5	3
Randall	16	1
Tom Green	15	3
Travis	13	9
Trinity	6	1
Uvalde	20	2
Walker	6	1
Wharton	3	1
Williamson	13	1
not specf'd		5

Demographic Information

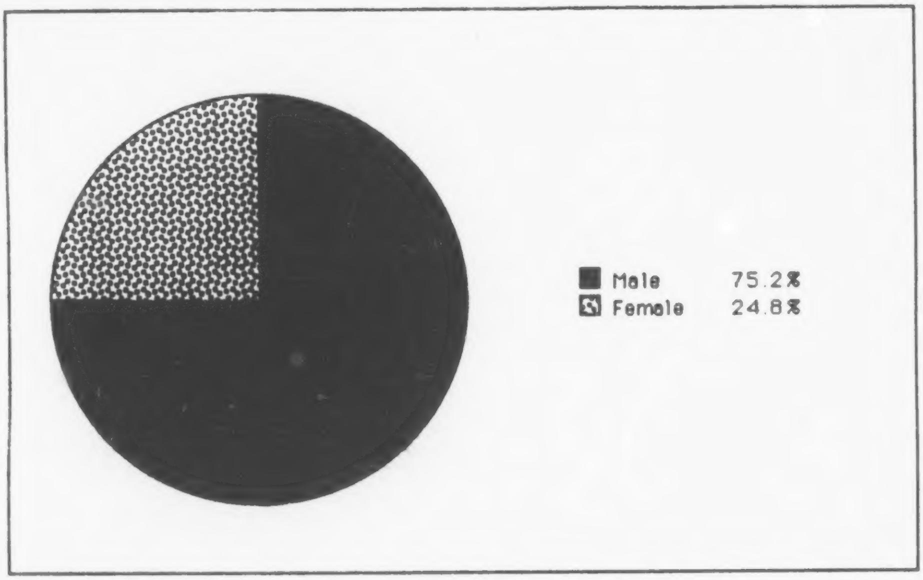
Age information.



Grade or education status.



Gender makeup.



Additional Diagnoses, if Any, Reported by Parents

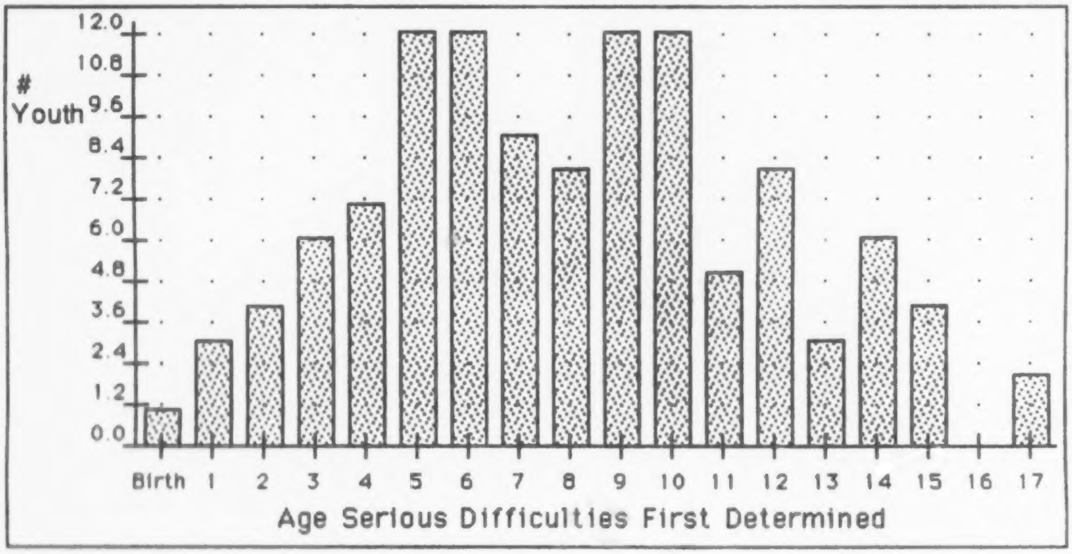
Fifty-seven percent of youth were reported to have additional diagnoses. The most frequent additional diagnosis (13%) was ADD/ADHD/Hyperactive.

Additional Diagnoses Reported, If Any

	N	Percent
No additional diagnoses	68	57%
Yes, additional diagnoses (see below)	52	43%
Of those with add'l diagnoses, the following were indicated		
Diagnoses not specified	5	4%
ADD/ADHD/Hyperactive	16	13%
Learning Disabled	7	6%
PDD, atypical PDD	3	3%
Depression/Major Depression/PDD	5	4%
MH	2	2%
MR	4	3%

Determination of Serious Difficulties

Age serious difficulties were first determined. The age-range during which serious difficulties were reported to be first determined appears to lie between 5 and 10 years of age.



Person(s) who first determined serious difficulties (frequency). It is clear that parents are among the first to determine serious difficulties. It is also clear that schools play a major role in the determination of serious difficulties. It is not clear whether or not the "psychologist" is school affiliated or a private provider.

Person	N	Percent
Parents	56	47%
Psychologist	53	44%
Teacher	51	43%
School counselor	42	35%
Psychiatrist	24	20%
Private MD	14	12%
Other School Staff	11	9%
Principal	2	
CPS	2	
Juvenile Authority	3	
Grandparents	2	
MHMR, DHS	2	
ESC	1	
Social Worker	1	

Services Received and Service Providers for Both Populations

Special ed services received. Effectively, every child received/receives services in special education.

Special Education Services Received and Arrangement

a. Have not received special education services: 5%
b. Have received special education services: 95%

Service arrangement:	Resource	52%
	Partially self-contained	21%
	Self-contained	26%
	Separate campus	13%
	Other:	10%
	Counseling	2%
	Campsite classroom	1%
	Study skills	1%
	BIC	3%
	not specified	2%
	Speech therapy	1%
	Mainstreamed	1%
	Homebound	1%
	CMC	1%

Services received from all sources. Direct therapeutic services received are the primary services received.

Services Received (frequency) as Reported by Parents

Type of Service	N	Percent
Individual Therapy	89	74%
Family Therapy	56	47%
Medication Management	44	37%
Parents Support Group	26	22%
Sibilng Therapy	17	14%
Individual Support Group	13	11%
Respite Care	5	4%
Sibling Support Group	2	2%
Family Monitoring	1	1%
Therapeutic Horseback Riding	1	1%
None	6	5%

Service providers (frequency). Clearly, private providers deliver most and more of the services (59%) for youth.

Major Service Providers	
Private	41%
ISD/Cooperative	16%
MHMR	15%
Hospital Inpatient	14%
Hospital Outpatient	9%
Community Non-Profit	5%

Perceived adequacy of services. A clear majority of parents (72%) feel that services are adequate only to some degree or not adequate at all. Roughly 25% feel that adequate services are available for child or child and family.

Are Adequate Services Available? Parental Perceptions	
No	41%
To some degree	31%
Yes, for child & family	25%
Yes, for child only	2%

Services desired.

Services Desired: Open-Ended Parent Responses (frequency)

Type/Nature of Service Desired	N	Percent
Psych/Counseling Services		
Counseling: child/family/individual	25	21%
Equally accessible/affordable psych svces	13	11%
Emergency counseling/crisis intervention	6	5%
Accessible MHMR svces	6	5%
Alternative/Expanded Care Services		
Respite care: any and more	12	10%
B/f & after sch daycare, activities/supervision	9	8%
Specialized daycare/activities for disabled	5	4%
School Related		
Increased teacher/diagnostician training	9	8%
Vocational teaching/expanded curriculum	6	5%
Support Groups/Non-Professional Training		
Parent support group	12	10%
Teen/youth support groups	6	5%
Parent training	3	3%
Other		
Networking of services; comprehensive listing & referral; ombudsman/info sharing	5	4%
Help in general	3	3%

Services Desired: Forced Choice Responses (frequency)

Service Desired	N	Percent
Individual Counseling	69	57%
Parent Counseling	56	47%
Family Counseling	53	44%
Parent Skills Training	50	42%
Parent Support Groups	50	42%
Case Management	26	22%
Individual Support Groups	33	28%
Respite/Relief Care	24	20%
Medication Management	19	16%
Sibling Support Groups	23	19%
Other	7	6%

Case Management

In nearly 70 percent of cases, the school's special education staff serve a case management function for youth with serious difficulties. Parents clearly view the school as the hub of services for children with serious difficulties.

Case Management: Reported Providers (frequency)

Provider	N	Percent
Parents only	15	13%
or parents in combination with one or more below:		
Special education staff	81	68%
Private provider	27	23%
MHMR staff	16	13%
Private physician	14	12%
Another family member or friend	9	8%
Other	9	8%

Of the 120 parent(s) who responded to the Task Force Parent Survey, 42% have children who have been residentially placed. The following results were answered by parents of those students.

Residential Placement of Respondents' Children

Ever Placed	N	Percent
Yes	49	42%
No	68	58%

Number of Residential Facilities in Which Placed

A total of 44% of children have been in more than one residential facility. Twenty-two percent have been in two facilities and 22% in three or more facilities.

# Facilities	N	Percent
1	28	56%
2	11	22%
3	5	10%
4	2	4%
5	1	2%
6	2	4%
7	1	2%

Parental Satisfaction with Residential Placement

Most parents (55%) expressed satisfaction with residential placement, however improvement in the child's condition was not a precondition for satisfaction with the residential placement.

Rows C and D clearly represent cases in which no improvement was evident (48%). However Row C indicates that 24% of these parents expressed satisfaction despite lack of evidence of improvement. This may indicate parental relief that the lack of a positive outcome was not solely associated with the particular family situation and/or parenting capabilities. It may also indicate that the respite provided by any type of residential placement provides needed relief on a strained family system.

Row	Status	N	Percent
A	Still in (satisfaction level not yet determined)	10	20%
B	At home Child improved Parents satisfied	15	31%
C	At home Child not improved Parents satisfied	12	24%
D	Not satisfied	12	24%

Major Reasons for Placement

Reason for Placement	(frequency)
Aggressive behavior, angry, out of control, temper, violent, suicidal, homicidal	25
Runs away/skips school	6
ADHD/short attention span/hyperactivity	6
Depression	5
Trouble with the law	4
Oppositional behavior	3
To help him/her with problems	3
Anti-social/social problem	3
ED	2
Acting out	2
Behavior problems	2
Medication management	2
Other: multihandicapped, delusions, anxiety disorder, self-abusive, stealing, paranoia, non-compliant, low self-esteem, failing grade	1 each

Major Factors Influencing Placement

Far from being oblivious, parents clearly indicated knowledge of their children's needs, sources of the problem, and an awareness of the lack of available services in the school and community.

Factors Influencing Placement	Frequency
Lack of appropriate/affordable services at school and/or in the community	23
Family factors, including specific mention of the following: father deserted, divorce/separation, new brother, influence on sister, sibling rivalry, family dynamics, emotional abuse by stepfather, no friends/only child	13
Lack of financial security/insurance	3
Last ditch effort	2
Removal from sports	1
Other: needed 24-hour monitoring, medical problems, parents knowledge of psychology, dangerous	1 each

Services Obtained from Residential Placement

The type of services obtained paralled the reported services offered by facilities responding to the residential facility study instrument, however, the level of core services obtained falls, on the average, aproximately 38% below what facilities stated were minimum psychological services provided.

Service Obtained	N	Percent
Individual therapy	36	73%
Group therapy	25	57%
Family therapy	24	49%
Medication management	19	39%
Parent support group	12	24%
None	4	8%
Recreational therapy	1	
12-Step Program	1	

Follow-Up Services, if Any, After Discharge.

Follow-up services actually provided broadly paralleled what facilities reported are offered in the residential facility study instrument. For children with severe emotional disturbance, however, the level and range of services offered fell below that for children who are not.

Follow-up Service Obtained	Frequency	Percent
Individual therapy	22	45%
at additional charge	15	
no additional charge	6	
Family therapy	18	37%
at additional charge	15	
no additional charge	3	
Medication management	14	29%
Personal follow-up (phone, letter or visit)	11	22%
Family or individual support group	11	22%
Referral to community resources	8	16%
Parent training	7	14%
Day treatment	4	8%

THE DEVELOPMENT OF EMOTIONAL PROBLEMS IN CHILDREN AND ADOLESCENTS

Serious emotional problems in children and adolescents have been linked with poor school performance, problems in relations, deficient job performance, delinquency, and adult pathology. It is the purpose of this paper to discuss biological, sociocultural, family, and environmental influences that may contribute to the development of serious emotional disturbances in childhood. Authors suggest that childhood disturbance leads to adult maladjustment and mental disorders. The Joint Task Force was requested by the 71st Texas Legislature to make recommendations regarding proposed legislation to create and evaluate programs for children at risk for emotional disturbance. At the present time the task force reports a lag in identification of children and adolescents with serious emotional disturbance as well as a high dropout rate for this population once they have been identified.

Biological and predisposing factors have been suggested by many authors. Genetic abnormalities have been associated with several kinds of psychopathology, such as juvenile delinquency and problems in gender identity (Wright, Schaefer, & Solomon, 1979). Physical characteristics, such as muscularity, have been associated with delinquency and aggression (Glueck & Glueck, 1968). Physical unattractiveness seems to be linked with emotional problems (Noles, Cash, & Winstead, 1986). Longitudinal studies have shown that difficult temperament in children has been associated with patterns of abuse and neglect (Maurer, Caderot, & Cain, 1980). Language delays have been associated with behavior problems in children (Camarata and others, 1988). Children who have a parent diagnosed as either schizophrenic or depressed have higher rates of emotional instability, interpersonal disharmony, academic difficulties, and lower intelligence (Janes et al., 1983; Watt et al., 1982; Lambert, 1987).

Environmental factors such as institutionalization and early deprivation have been associated with learning, emotional, and behavior problems in children (Burnstein, 1981; Knight, 1981). Hawkins and Duncan (1985) have identified five factors that were common in abused children. They were chronic illness, physical handicaps, hyperactivity, mental retardation, and child management difficulties. Certain other variables are associated with antisocial behavior, such as poverty, poor training in parenting, and discipline practices. Recent work by Dishion, Patterson, and Reid (1985) report that parents who were heavy substance abusers tend to have parenting and management difficulties. Early traumas, especially, repeated disruption in normal personality development (Crittenden, 1985; Owens, 1984).

Social influences that have been linked to emotional and behavior problems include low socioeconomic class (Eron & Peterson, 1982), disorder-engendering roles, prejudice and discrimination, economic and parent employment problems (Dooley & Catalano, 1980), homelessness (Bassuk, Lauriat, & Rubin, 1986), and divorce.

In summary, these factors usually operate in concert with each other. No single factor is the major cause for disturbance in children, but the combining of these characteristics is usually found as predictive of severe emotional problems in children. Even the predisposing biological factors are not enough to cause major disturbance, but coupled with social and environmental stressors, children are usually found to be diagnosed as emotionally disturbed. When many factors are present, it would seem that the most severe and incapacitating conditions occur.

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PREVENTION STRATEGIES:
THE STATUS OF COUNSELING SERVICES TO PREVENT EMOTIONAL DISTURBANCE IN PUBLIC SCHOOLS OF TEXAS

The Joint Texas Education Agency/Texas Department of Mental Health and Mental Retardation Task Force on Emotional Disturbance was given as one of its charges by the Texas Legislature (Senate Bill 417, Sec. 1.11) the following task:

> "...to conduct a study to evaluate and make recommendations concerning...early intervention and prevention strategies including early identification of students with emotional disabilities."

Making recommendations regarding intervention systems in public schools for the purpose of preventing emotional disturbance calls for, at the least, some idea of the status of such efforts already undertaken by the schools. Such information was not available to the task force.

To acquire a baseline about schools' present efforts in prevention of emotional disturbance, a questionnaire was devised by the Joint Task Force which asked school staff what they are doing to prevent emotional disturbance, what services they feel they need, which services are the most effective, and what services they have within special education for students already identified as emotionally disturbed. It was specifically made clear that the prevention services being discussed were to be found within the realm of regular education, not special education. (See Appendix for the survey.) Prevention was defined as the status of the efforts of Texas schools to prevent emotional disturbance within the realm of regular education activity.

One hundred and forty-one responses were obtained. The responses represent every size of district in the state and every region except one.

	REGION																		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	20	T
Dist. Size*																				
A							5	1		3	1	2				4		1		17
B		2	2		1	2	5		1	3	3	3	3	3	2	1	2		1	34
C		4	1	5		5	3	3	3	1	4	4	1	2	3	1	2	3	2	47
D	2	1	1	3	1	1	1	2		2	4	2	2							22
E	1	1		1			1		1	4	1	1	1					3	6	21
																			Total	141

District size A- 1-499 membership
B- 500-999 membership
C- 1000-2999 membership
D- 3000-10000 membership
E- over 10000 membership

Surveys were sent to the director of counseling/head counselor in each district in Texas large enough to have a high school. The responses were

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collected over a period of approximately two months. The following information was obtained from the results of these surveys.

Schools with No Services

Whether a school reports no services at all to prevent emotional disturbance is a direct function of school district size (and it is the only aspect of the issue that is a function of size).

The number of schools reporting no preventive services goes down directly in proportion to the size of the district with one qualifier: at the high school level, the lack of prevention services when the very small districts (1-499 membership) are excluded is not affected by size of the district.

Number of Preventive Services Offered

The number of programs and strategies which the school uses to prevent emotional problems is not related to the size of the district in any clear way (with perhaps, again, the very small districts being the only exception). The schools which appear to be doing the most to prevent emotional problems, as determined by the number and kind of prevention services they report, are the small districts (size 500-999).

Variety and Creativity of Preventive Approaches

There is no rationale for believing that the small- and medium-size districts in this survey are more amply funded than any other districts. Therefore, the number of different types of strategies which they report to prevent emotional problems can be viewed as a measure of the creativity that is being expended to meet the challenge. In this regard, size of the district bears an inverse-U relationship to variety of approaches employed by the small- and mid-size districts (500-999 and 1000-2999) clearly employing a greater variety of preventive approaches.

Degree to Which Counseling Is Employed in Prevention

As the size of the district goes up, counseling is employed less often in prevention, and the prevention approaches that are based upon counseling approaches go down.

Special Education Services for Students Identified as Emotionally Disturbed

Since the services of special education are mandated for students identified as emotionally disturbed, one might suppose that special education services would lead all services being reported by schools within the area of emotional disturbance. This is not the case: the exact opposite seems true, i.e., special education services to students identified as emotionally disturbed shadow the services of the schools within regular education to prevent emotional disturbance.

Need for Preventive Services

Rather surprisingly, schools perceive their needs for preventive services almost directly in line with the amount of services they already report.

Those who are already doing the most perceive the highest need for other services.

Elementary vs. Secondary Services

It appears to be a common belief that elementary prevention services are the major area of need and that high school services are well provided for. The results of this survey call that assumption into question. The relationship is not always consistent. In some cases, elementary services exceed secondary services. The group that appears to be in most need of attention is the middle school population.

It is especially the largest districts which have the most need to attend to the elementary and middle school populations.

Professional-Intensive Programs

Different approaches to prevention may be related to the size of the district. The smaller districts appear to use approaches like in-school guidance units and professional services most directly. The larger schools employ crisis approaches and peer approaches more consistently, apparently in an effort to spread the professional input as far as possible.

Content of Perceived Needs

For every size district at every level, the number one perceived need is reported to be professional time: more professionals who have more time to perform counseling and psychological functions. This ranges from about two-thirds of the responses for the very small schools to about a third to a quarter of all the other responses.

Other strongly mentioned needs (varying around 15-25% of the total responses) are:
. the services of a psychologist;
. parent training, involvement, and support groups; and
. more group counseling, and the time to do it.

These needs do not vary between grade levels of the schools or by district size to any appreciable degree.

Other responses that occur with some frequency include:
. earlier intervention;
. inservice on the signs of emotional distress;
. specialized groups (drugs, sex. etc.);
. social skills training; and
. especially for the high school, alternative curricula.

Most Effective Present Strategies

The majority of responders did not attempt to evaluate their services, and when they did, the most common response was a "we need everything we have" type of response. Because of the reaction to this question, no attempt is made to answer it in this study because the conclusions would not be reliable.

Several responders noted frustration at their inability to evaluate their strategies.

Discussion

These data have supplied a number of rather surprising results. The fact that a lack of services can be directly related to school district size is not surprising; however, the opposite, that the presence of services cannot be related to district size, is surprising. In addition, it is an unanticipated result that small schools appear so creative in the extent of services they are using.

A limitation of the data on very large districts (over 10,000) is the fact that the majority of these respondents (15) did not supply information about any but the high school level. This may be because the surveys found their way to high schools. It is a matter of concern that information about the programs and services at lower levels of the systems were not or could not be reported. This raises a concern about the continuity of prevention programs and services in very large systems and the awareness of that continuity among staff.

Finally, another limitation is the fact that much unique data cannot be reported here. Obviously, there are sincere professional counselors across the state who are putting up massive efforts in the interests of children's mental health. Many of their remarks show this. However, there are a few (actually very few) who do not accept a role in the prevention of emotional disturbance in children. Preventive efforts made in schools are not consistent. When there are preventive services, however, there tends to be greater depth and scope than might have been anticipated. These service deliverers say their number one need is for more professional help. Their analyses underscore this need.

Conclusions and Recommendations

1. The number one problem in the prevention of emotional disturbance in Texas school children is those schools which offer no preventive services. These districts constitute the "holes" in the system.

   Recommendation: Schools should be allowed to develop their own prevention plans for students' mental health as schools have shown much creativity and resourcefulness in doing this. Nevertheless, every school district should be required to have such a plan and it should be monitored by the state education agency.

2. Efforts to further consolidate school districts past a reasonable size for the purpose of financial savings or other supposed benefits, including offering low-demand, specialized courses, should be resisted. Results of this study call in question the ability of school personnel, no matter how dedicated, to deal with massive numbers of students on a humane, affective basis. Evidence for this point of view is seen in the drop in types of preventive services offered as size increases beyond a certain point, the stretching of professional care by dependence on crisis approaches and strategies involving less counseling expertise, and other signs that such schools lose track of the continuity of the student's individual progress.

Recommendation: Limit the efforts to further consolidate and enlarge school districts beyond perhaps the very small districts (fewer than some point in membership below 500). Use approaches that "break-up" large schools into smaller working units.

3. Where school districts do have prevention programs, they show much inventiveness and effort on the part of local counseling staff. Many counselors, however, cite a lack of time as preventing them from doing things they already know need doing. Many report being saddled with non-counseling duties.

   Recommendation: Increase the allocation of counselors to districts. Specify their function in rule and limit the amount of administrative/ paperwork duties they may perform, including routine scheduling of classes. Provide opportunities for increased training through a strong professional sequence of training on current topics and methodologies, and offer this training through the service centers.

4. Counselors perceive a serious need for the "back-up" of available psychological services in schools. They need psychological assessment to be available when needed and the assistance of additional expert consultation on serious situations.

   Recommendation: Every school should have an available avenue for procuring psychological services. This provision needs to be a part of a school's available funding.

5. The fruitfulness of the small- to medium-size districts in their efforts to prevent emotional distress in their students was a surprising finding. The factors that produce this rather unexpected result are not clear.

   Recommendation: A follow-up study should be made to determine the factors that produce a higher effort toward preventing emotional problems in the small- to medium-size schools. Does this result from knowing the students better over time, not having them move between so many buildings, the sheer "do-ability" of more human-size organizations, more parental involvement? Such a study, especially if it finds less emotional disturbance in the population as a consequence of these factors, would have implications for the prevention of emotional disturbance in the population of the entire state.

6. Services for students identified as emotionally disturbed do not appear to "lead" mental health services in a school but to follow the general trend of concern and effort. This would suggest that much emotional disturbance may actually result from a lack of school programming that focuses on students' mental health. Efforts to better provide for students identified as emotionally disturbed in a school system need to be extended to the general population.

   Recommendation: Allow some percentage of special education funds to be spent upon specified preventive services in the regular or at-risk population, both programmatically and individually. Require (in the mandated prevention plan, Recommendation #1) that such interface and use of time be articulated.

7. It appears from these data that counselors see a very strong need for students to have a sense of belonging and self-esteem. Repeatedly, counselors report these concerns and the use of strategies to meet these needs. The affective and social "curriculum" of schools is not honored and recognized as is the "academic" curriculum. This is not in line with the realities of 1990, nor is it, in fact, in line with the original purpose of public education, which was solely the purpose of producing good citizenship.

   Recommendation: The social and affective curriculum should be recognized as legitimate essential elements of the academic curriculum. This means that time needs to be provided in the school day for social and affective needs of students. Counselors should be the persons in the school to organize, articulate, and provide a social and affective curriculum for each school campus.

AVERAGE NUMBER OF PREVENTIVE PROGRAMS AND STRATEGIES BY DISTRICT SIZE AND LEVEL

Size of District	N	Average number of services+	Average need for services	N with no services	% with no services
			Elementary Level		
1-499	15	1.14	0.84	6	40%
500-999	34	1.97	1.29	8	29%
1000-2999	47	1.67	1.23	7	15%
3000-10000	23	1.53	1.35	2	09%
Over 10000	22	*	*	1	05%
			Middle School Level		
1-499	15	1.15	0.71	5	33%
500-999	34	2.12	1.41	6	18%
1000-2999	47	1.50	1.33	8	17%
3000-10000	23	1.79	1.50	1	04%
Over 10000	22	*	*	1	05%
			High School Level		
1-499	15	1.07	0.77	6	40%
500-999	34	2.00	1.63	3	09%
1000-2999	47	1.85	1.39	4	09%
3000-10000	23	2.05	1.33	2	09%
Over 10000	22	2.14	1.57	2	09%

* Figures for schools over 10,000 at the elementary and middle school level are not reliable because (1) 15 of the 22 schools reporting did not fill in information for the elementary and middle school levels, and (2) one school among the seven greatly inflated the averages because the services it offered were over three times as high as any other school. Nevertheless, given these constraints, these figures are as follows:

Schools Over 10,000:

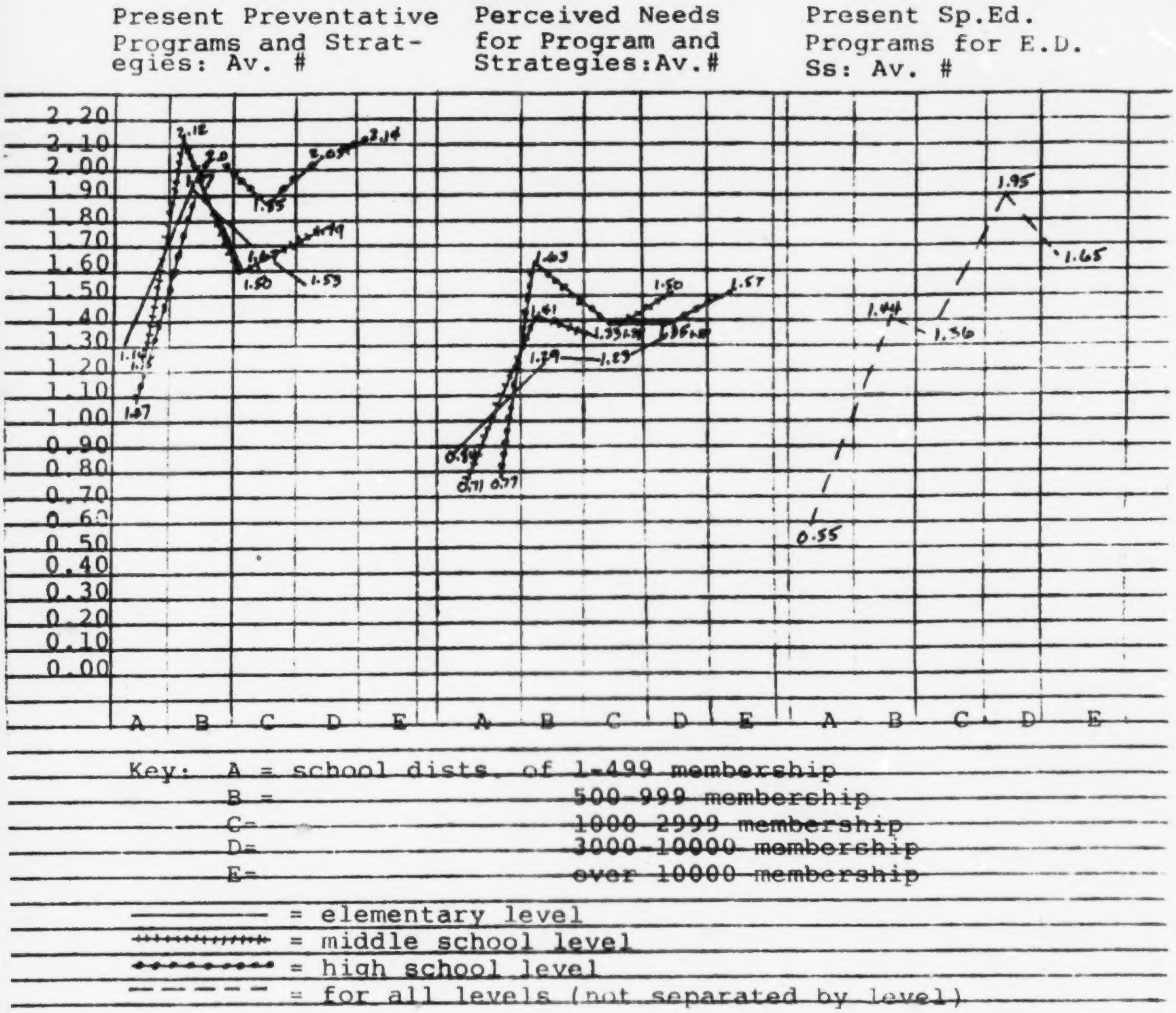
Average no. of services for the seven reporting:
elementary 2.42 (w/out the exceptional school, 2.0)
middle school 2.85 (w/out the exceptional school, 2.60)

Average no. of services counting totals N (with 15 at 0):
elementary school - 0.82; middle schools - 0.91

None of these figures can be considered representative, given the constraints of the data. Please see discussion section.

+Note: These averages include zero schools, i.e., schools reporting no services.

GRAPH 1


Present Preventative Programs and Strategies: Av. #
Perceived Needs for Program and Strategies:Av.#
Present Sp.Ed. Programs for E.D. Ss: Av. #
2.20
2.10
2.00
1.90
1.80
1.70
1.60
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1.40
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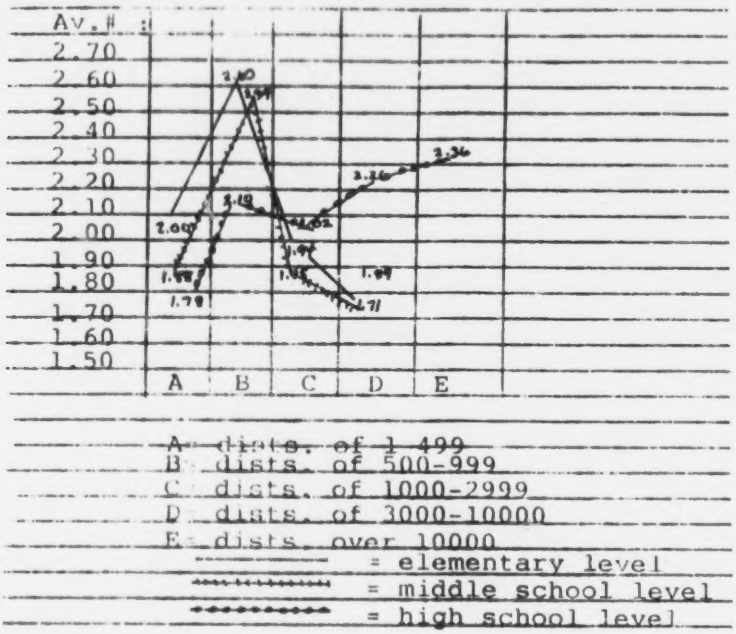
Key: A = school dists. of 1-499 membership
B = 500-999 membership
C= 1000-2999 membership
D= 3000-10000 membership
E= over 10000 membership
= elementary level
= middle school level
= high school level
= for all levels (not separated by level)

GRAPH 2



Average Numbers of Services by District Size and Level: Schools WITH Services Only

Elementary Level:

Dists. 1-499	2.00 av. number of services
500-999	2.60
1000-2999	1.94
3000-10000	1.71
Over 10000	See discussion section

Middle School Level:

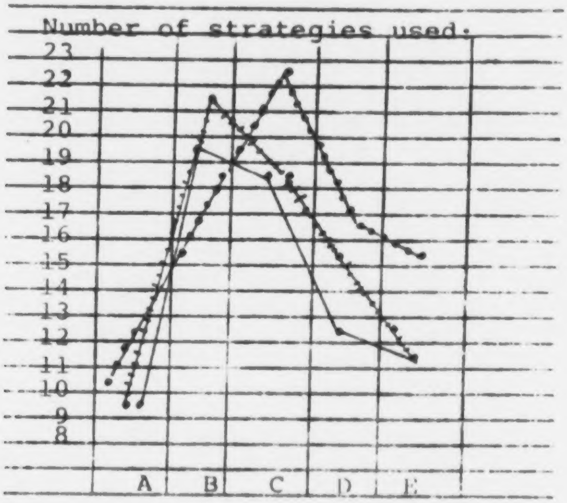
Dists. 1-499	1.88
500-999	2.59
1000-2999	1.85
3000-10000	1.89
Over 10000	See discussion section

High School Level:

Dists. 1-499	1.78
500-999	2.10
1000-2999	2.02
3000-10000	2.26
Over 10000	2.36

Number of Strategies Employed by Dist. Size and Level

Graph 3



—— = elementary school level
See key ⋯⋯ = middle school level
to dist. •••• = high school level
size below

MOST-USED STRATEGIES BY DIST. SIZE AND LEVEL

Note+

	Elementary					Middle School					High School				
	A	B	C	D	E	A	B	C	D	E	A	B	C	D	E
Traditional counseling	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Group counseling		X	X	X	X	X	X	X				X	X		
Targeted Subjects Co.		X		X			X					X	X	X	X
Peer Counseling														X	
Crisis Teams					X					X					
In-class guidance units		X	X				X								
PALS		X						X				X			
Parental consult.									X						
SAPS														X	X
Peer support groups									X					X	X
Behavior Manage. Plans									X						
Referral	X					X					X	X			
Outside services									X						

A=dist. size 1-499
B= dist. size 500-999
C= dist. size 1000-2999
D= dist. size 3000-10000
E= over 10000

+Clear 2-5 top preferences

THE STUDENT ASSISTANCE PROGRAM:
A PREVENTIVE PROGRAM FOR CHILDREN AND ADOLESCENTS

Concern about inadequate mental health care for our children is not new. Conferences, panels, and commissions examining the topic span this century (Tuma, 1989). Major findings of these efforts repeat the same message: Adequate and comprehensive services are not available to a large number of disturbed and disruptive children. Furthermore, available services are unnecessarily restrictive and poor children are at particular risk (Tuma, 1989).

Over 12 years ago, the President's Commission on Mental Health (1978) found that children and youth continued to receive inadequate mental health care. Services were frequently unavailable, the available services were characterized by mental health personnel shortages, and the identification of the needs of children were often isolated. Furthermore, when children's needs were addressed, they were addressed separately by different specialists with children shuttled from service to service. More recent analyses show that the United States continues to have serious deficiencies in the mental health care of our children.

In 1989, the Mental Health Association in Texas published Do Kids Count, an investigation of how Texas serves children and adolescents with severe emotional disturbance, focusing on the barriers to the development of an effective mental health service system for Texas children. Gaps in services, insufficient interagency planning and coordination, inadequate funding, and lack of attention to children's policy development are identified as the major obstacles.

The establishment of a child advocacy system to coordinate a comprehensive network to meet children's mental health, physical, and social needs has been recommended repeatedly. This recommended system would involve federal, state, and local services and include both prevention (e.g., family planning, mental health services in schools) and remediation services (i.e., mental health services based on a child's functional level).

This report recommends that Texas make a long-term commitment to prevention and early intervention programming for children. In addition to expanding other programs, it recommends that the Texas Education Agency urge school districts to permit non-faculty mental health professionals to work in the schools to provide counseling before students become severely emotionally disturbed.

This paper presents the Student Assistance Program (SAP) model as a system for improving mental health services to children. The SAP Model focuses on comprehensive services delivered to high-risk students in a school setting. High-risk students include those who are experiencing behavioral difficulties as a result of non-academic problems. These services of the SAP model include early identification, in-school support group intervention, and referral of high-risk students to community resources for assessment and treatment.

Overview

A SAP shares the basic premise of employee assistance programs: When an employee develops substance abuse or mental health problems, his or her performance is impaired, resulting in a decline in productivity. Similarly, a student's school performance will be adversely affected by substance abuse or mental health problems. When these and/or other emotional problems are addressed directly, the individual's capacity to function effectively increases.

Originally, SAP efforts focused on students at risk for alcohol- and other drug-related problems (AOD). More recently, the SAP model has been expanded to include students at risk for other mental health problems. For example, the Pennsylvania SAP, an outgrowth of statewide AOD educational efforts, now involves a teen suicide prevention component.

The school setting is often the first place the full scope of a student's problems are manifested. Therefore, educational systems are becoming logical arenas for prevention and intervention with youth who are having difficulties due to their own or a family member's mental disorders and/or substance abuse. While there is broad acceptance that AOD use presents problems for young people, the correlation between AOD use and lack of academic success has only recently been the focus of research endeavors. The results of the 1987 survey conducted by the New Jersey Department of Law and Public Safety found that 75% of the students who drink alcohol or smoke marijuana regularly self-reported a high percentage of failing or near-failing grades (Fisher, 1987; cited in Borris, 1988). Other stressors (e.g., divorce, poverty, physical abuse, relocation) experienced by students also interfere with their progress and may pose a significant threat to their mental health. And most often children and families experience several major stressors at one time.

SAPs are designed to prevent and reduce a range of student problems--substance abuse, teen pregnancy, suicide, truancy, dropout, violence, child abuse, behavior problems, and other serious life issues. Reported benefits of SAPs include decreased vandalism, increased student participation in alcohol- and drug-free functions, more positive attitudes toward youth with problems, and improved communication between students, staff, community, and parents. An additional benefit is a decreased drop-out rate for students with problems.

Regularly scheduled small group counseling sessions are an integral primary component of most SAPs. They are comprised of students with similar needs, such as a children of alcoholics or children suffering from depression. Groups offer support, education, and coping skills training. They facilitate life skills development by providing a safe, supportive atmosphere in which students can learn and practice skills that will enable them to cope more effectively with problems.

Support groups are an essential SAP component for several reasons. Groups promote constructive behavior changes. Often, learning healthier behaviors requires a great deal of education, illustration, and support. Changing resistant behaviors requires an environment that is safer and more supportive of change than that provided by a student's routine associations with other students, family members, and even staff members (Anderson, 1987). Constructive change is difficult because the behaviors are both new and risky.

Support groups offer an opportunity for students to experiment with and practice the new behaviors before trying them out in the "real world." Additionally, soliciting group members' support, ideas, and suggestions provides the student with realistic alternative behaviors that she/he would typically not think of.

On-campus support groups allow counselors or group leaders to help more students than would normally be possible for the average counselor. In theory, a group leader can accomplish with eight students in one hour what would take eight hours if each was seen individually (Anderson, 1987). Thus, as campuses offer more weekly support groups, the number of students receiving this assistance increases greatly. Support groups are sometimes facilitated by classroom teachers and outside volunteers, so that the number of students receiving help is increased even more.

Another important advantage offered by on-campus support groups stems from the nature of the developmental needs of students. Support groups are made up of other children or adolescents facing similar problems and tasks and provide a developmentally appropriate context within which to discover, examine, and experiment with change. Students often seek help from peers rather than adults when facing difficulty and may gravitate to dysfunctional groups such as gangs to meet needs for security and acceptance. Dysfunctional peer association is replaced with functional problem-solving support groups. The support groups offer a safe and supportive environment in which to confront maladaptive family rules such as the "Don't Talk" or "Don't Feel" rules common in dysfunctional families where chemical abuse often occurs. Also, support groups offer an opportunity for students to explore issues regarding peer group pressure and decision-making (Anderson, 1987).

Finally, support groups tend to boost the self-esteem of the participants; students can see themselves as helpful to others. Additionally, the trust-building mechanisms of the group allow students increased opportunity for asking and receiving help.

Major Student Assistance Program Models

SAPs aim to remove obstacles to learning and improve the quality of students' lives. They rely on early identification of student problems and interventions such as in-school support groups as well as referral for assessment and treatment. SAPs have been implemented on both elementary and secondary levels, and in rural as well as urban communities. Successful implementation requires that the model be adapted to fit the needs and resources of the specific educational setting. While three major organizational models constitute the bulk of SAP programs to date, other program types have proven their effectiveness as well.

The three traditional models include: the core team model, the externally-based model, and the internally-based model. Each will be presented along with a fourth model which combines elements from several traditional models and represents an innovative evolution of the program.

Core Team Model

In this model, a group of school-based staff work together to coordinate student assistance services. The exact composition of each team varies according to interest, availability, and schedules. Typically, a core team consists of an administrator, a guidance counselor, a teacher, and at least two other staff members (one of whom is often a nurse). Regularly scheduled core team meetings focus on the progress of individual students and include an assessment of the need for intervention with students who exhibit high-risk behaviors. The varied membership of the core team provides a well balanced opportunity to look at students' behavior in terms of classroom performance, discipline, attendance, medical information, and other vital factors.

The core team approach has been successful for a number of statewide programs (e.g., Pennsylvania, Wisconsin, Minnesota) as well as for numerous local school districts. This model offers a number of benefits.

. The shared sense of program responsibility encourages professional networking, both within campuses and with other agencies.

. Implementation costs are relatively low since staff members often volunteer their time.

. Because the core team consists of campus staff, there is less likely to be resistance from school administrators, school boards, and teachers.

One limitation of the core team approach is that with the shared sense of leadership, the group may become unfocused and coordination of services is sometimes lacking. Another limitation sometimes results from the lack of compensation, either in salary or release time. Enthusiastic core team members too often experience some "burn out" after several years of non-compensated SAP work.

Externally-Based SAP

In this model, student assistance services are provided by outside agencies and by trained professionals. These professionals work a number of hours each week providing on-campus services ranging from individual counseling to teacher training. One strength of this type of program is the confidentiality and level of trust that students develop with the SAP counselors. Some students tend to believe that someone "outside" the school is more likely to keep information confidential. Less time may be needed to develop resources because most contracted professionals who serve as SAP counselors already have well-developed relationships with other community resources. Furthermore, a strong referral system among students and staff is developed due to the novelty of being noticeable and "special" on campus.

Since these programs involve non-school professionals who are not campus-based, the SAP services sometimes are not well integrated with the students' on-campus behavior and achievement. Another disadvantage is that this type of SAP downplays the school's role in coordinating services and monitoring student progress.

Internally-Based SAP

This SAP model is composed of staff hired by the school district specifically to perform student assistance services. The program may be part of the campus guidance system or an entirely separate program. Although staff members may be counselors, nurses, teachers, or other school personnel, they are often professionals with such titles as "chemical health coordinator" or "student assistance counselor." One asset of this type of program is that coordination is centralized within the school or district. Specifically, policy developments and needs identification are facilitated. This model also allows for flexibility of scheduling and helps staff build networks and trust.

One obstacle to this type of program is the additional expense to the district; it is often the most expensive to implement. Other liabilities include credentialing and territorial issues that may arise involving guidance staff and child study teams; supervision difficulties may occur when multiple campuses are involved; and school boards may argue against the cost justification of an internally-based SAP as a "supportive service" when educational services compete for the same funds.

Combination of Core Team and Internally-Based SAP

While many innovative programs are possible, one promising model involves distinctive elements of the core team model and the internally-based model. This approach involves establishing a core team of diverse, trained campus personnel to review referrals, determine recommendations, and participate in interventions. Core team members also co-lead support groups for SAP students or parents and coordinate SAP activities such as a campus-wide "healthy living" fair, parenting skills lunches, and student leadership workshops. Campus counselors are core team members but also function as case managers who fulfill the same types of duties as the SAP counselors of internally-based models. SAP tasks may include coordinating services for SAP students, co-leading SAP support groups, and counseling individual students during crises. Clerical and paraprofessional staff provide support services to allow time for the SAP tasks.

Campuses using this approach often benefit from outside agency support as well. For example, support groups are often co-lead by a core team member and an agency volunteer. Thus, within a support group, the agency professionals contribute topical expertise while school staff members know about the school and family issues facing these students. Communication and networking are facilitated in this approach. Additionally, enthusiasm and school-community support for SAP may be generated by the program's high visibility and responsiveness to students' needs.

Critical Components

During its 15-year history, the SAP model has been implemented at both statewide (e.g., Wisconsin, Pennsylvania) and local levels. The following discussion focuses on suggested elements of local programs. A number of elements have consistently been associated with successful Student Assistance Programs. While specific elements such as those listed here are key aspects of most SAPs, the articulation of each varies. Flexibility is necessary because school communities vary not only in tangible characteristics such as demographics or financial support, but also in intangible characteristics such as school or community "culture." For additional information regarding statewide implementation, refer to Machtiger & Toth's (1989) presentation of the Pennsylvania SAP model.

1. District philosophy, policies, and procedures provide a framework for efficient, consistent, and legal management as well as other crisis-related situations (e.g., suicidal threat). A district philosophy is needed to represent the district's beliefs and values; district policy clarifies rights, roles, and responsibilities throughout the system, and procedures allow for on-site or building management of specific situations.

2. A multiple-step SAP process or system has proven an effective way to guide troubled students toward resolving their problems. Effective steps include: early identification, initial action, preliminary assessment, referral to needed services, appropriate use of the continuum of care, and support for change (Muldoon, 1988).

   A successful program identifies troubled students before problems threaten the student's long-term school experiences. This identification of student problems is important because specific problem behaviors have been identified (e.g., poor attendance, frequent nurse visits, mood problems) that may indicate an AOD-related or other mental health problem. Typically, a campus-generated "behaviors of concern" checklist is used to document problem behaviors.

   After the problem has been identified, informal intervention (supportive counseling with student to determine nature and scope of the problem) or formal intervention (parent conference to recommend either in-school services or an assessment by an outside agency) follows. If school disciplinary policy has also been violated, appropriate disciplinary action is taken. Disciplinary action is considered separate from the SAP intervention and often may be probated if assessment or treatment has begun. When an out-of-school assessment is recommended, the staff help the family procure the resources necessary to help the student face and overcome the problems that are interfering with his/her education and social, emotional, or physical development. A monitoring system helps ensure that students take advantage of the opportunities presented. Finally, after a student initiates a plan for change, campus-based support is offered to make the changes permanent.

3. Comprehensive training for school district personnel is another vital element of successful SAPs. Training includes the presentation of the SAP philosophy and referral and program procedures. The core team model suggests that training involve experiential, team building, and personal growth exercises as well as relevant didactic experiences (e.g., child development, AOD information, crisis intervention). The counselor model places SAP counselors on campuses following specific SAP training. For example, in Westchester County, New Jersey, SAP counselors are placed on campuses following a month-long, full-time SAP training course. In addition, teacher training is considered critical. Training focuses on identifying specific behaviors that may indicate student distress or disturbance. SAP staff do not diagnose disorders (e.g., chemical

dependency) but rather through the SAP system, SAP staff refer students and their families to appropriate agencies and professionals for assessment and treatment when necessary.

4. Campus-based SAP services are a valuable element of successful SAPS. They vary, however, both with the different SAP models and different campus needs within each type of program. For example, the Westchester County program, geared toward short-term school counseling of students to prevent alcohol- and other drug-related problems, achieves its goals through time-limited groups. Six kinds of groups (three focused on primary prevention and three on secondary prevention or early intervention) are offered in addition to campus-based, short-term individual counseling before referral to an appropriate treatment agency.

   Similarly, support groups are important for many core team SAP programs. On-campus support groups offer an efficient and developmentally appropriate tool to address the primary and secondary prevention of AOD-related as well as other mental health problems of students. "Concerned persons" or children of alcoholics groups not only allow children of these dysfunctional families to express the painful effect associated with their home life, but also provide vital information regarding their heightened risk for AOD dependency. Similarly, support groups such as those for depressed or chemically dependent students provide support for change while also serving as a monitoring system for additional intervention.

5. Most successful SAPs involve joint school and community efforts. In addition to the specific in-school services, schools continually make referrals to outside agencies and professionals. Shared involvement and the establishment of strong networks between school personnel and outside agencies promote a more comprehensive address of children's needs. Networking between SAP staff and outside agency professionals promises to improve the provision of care for children.

6. Most successful programs include an evaluation component. Evaluation is necessary not only to show that the programs work and to gain continued fiscal support, but also to promote long-range planning. To have an impact on the student's life, SAPs must be sensitive to the current needs of the students. Program evaluation helps ensure that services address the particular obstacles interfering with students' academic and developmental progress. Process and product evaluation ensure that SAP services are successful on a particular campus and that, over time, the program continues to be effective.

7. There are other elements that have been identified as effective in SAPs. Some of these elements include ongoing staff development and inservice, mental health or affective education curriculum, employee assistance programs, peer assistance or leadership programs, and increased parent involvement. These programs benefit school community members by increasing awareness, skills, and support relevant to mental health issues.

Evaluation

The effects of SAPs can be measured through both direct and indirect data. For example, concrete data can be gathered on student participation in on-campus SAP services such as support groups, individual counseling, and drug-free events. Additionally, indirect assessment of SAP programs includes drop-out rates, improved GPA or test scores, improved attendance, decreased disciplinary action or criminal violations, and other baseline data. While comprehensive evaluations of SAPs are not common, the existing findings are favorable. For example, the results from the 1982-83 Westchester County, New Jersey, program (National Institute of Alcohol Abuse and Alcoholism, 1984) sampling of approximately 10% of the 2,000 student participants indicates that absenteeism decreased significantly as did AOD use. Additional data suggests that the program gained the enthusiastic support of school administrators, faculty, parents, and students.

The Phoenix High School SAP evaluation (Phoenix Union High School District, Number 210, 1987) reports that when 335 participants were surveyed, 61% of the previously AOD students reported either a decrease or cessation of chemical use following support group participation. The majority of these students reported gains in areas such as coping with problems, expressing feelings of self-worth, peer relations, and family relations.

The evaluation of the Banks, Oregon, (1989) program supports the effectiveness of SAPs. AOD policy violations decreased as the program was implemented. In 1986-87, there were 27 AOD violations for the school year. In 1987-88, there were 12 violations and as of February 1, 1989, only two had occurred for the school year. Additionally, strong student participation was noted for campus-wide health promoting services.

With regard to the evaluation of larger SAPs (e.g., statewide), Machtiger and Toth (1989) report that the success of the Pennsylvania SAP is seen in the campus demand for SAP training that surpasses the availability of state-provided services. As of 1989, staff from over 100 school districts were trained and over 6,000 Pennsylvania students received SAP services that ranged from on-campus counseling to inpatient hospitalization. Initial project evaluators examining a three-year demonstration project at five school districts, report that no serious obstacles to this broad-scale implementation were observed and that effective programs were operating at each site (Kelley & Peters, 1989).

Evaluations of SAPs are not complete and the full effects of these programs have yet to be examined. Nonetheless, the programs appear to benefit students as well as school communities. SAPs have been linked to improved student performance as well as to gains in important life skills such as problem-solving or communication skills. Additional research on the effectiveness of these programs should promote their value in preventing emotional and behavioral disturbances in children and adolescents.

Conclusion

The SAP model is a viable system for the prevention and early intervention of severe emotional disturbance in children and adolescents. It addresses a number of the changes recommended by recent federal and state reports (Tuma, 1989; MHAT, 1989). The SAP model offers a coordinated effort to identify and monitor students who are at risk for emotional disturbance. Often the referral and intervention process occurs within one to two weeks, and the model is an expeditious way to link troubled students with treatment before problems escalate. Furthermore, whether treatment consists of on-campus or off-campus services, the school community functions as a supportive and responsive agency. Student Assistance Programs recognize that specific problem behaviors sometimes signal greater difficulties and that long-term consequences associated with these difficulties may be prevented. The model offers a responsive, campus-based system to assess, intervene, and monitor the progress of distressed students.

On-campus support groups are efficient and effective vehicles for the prevention and early intervention of AOD-related and other problems. They allow students with a variety of problems to receive appropriate services (e.g., alcohol and other drugs, emotional, depressed and suicidal, delinquency, dysfunctional family) and they permit all students to be served. Furthermore, on campuses where well developed support group systems exist, students may join support groups within a week of referrals. Finally, support groups are cost-effective and allow for a large number of students to be treated with minimal cost.

Student Assistance Programs are not meant to replace current special education programs in schools. SAPs supplement and reinforce special education. Different goals underlie each type of program. Student Assistance Programs aim to identify students at risk for emotional disturbance and other mental health difficulties and prevent long-term obstacles to school performance. Special education programs provide for the individual educational needs of students with handicaps including those with emotional disturbances. Some special education students have benefitted from SAP services. Special education students with various handicapping conditions often participate in on-campus support groups with successful outcomes.

It is a sobering and disturbing fact that the daily stress experienced by many children threaten not only their academic functioning but their mental health as well. Unresolved crises experienced by children, such as physical or sexual abuse, poverty, divorce, or substance abuse, too often become serious, chronic psychological disturbance. Society's response to the needs of high-risk children remains inadequate. The Student Assistance Program model is a coordinated mechanism that can strengthen the community response to the needs of children and their families. Schools can make significant contributions to improving the lives of high-risk children and preventing of serious emotional disturbance through the implementation of these programs.

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Appendix A: Residential Facility Director Survey Instrument and List of Respondents

THE JOINT TEXAS EDUCATION AGENCY/THE TEXAS DEPARTMENT OF
MENTAL HEALTH AND MENTAL RETARDATION
TASK FORCE ON EMOTIONAL DISTURBANCE

February 12, 1990

TO FACILITY DIRECTOR

The Joint Texas Education/Texas Department of Mental Health and Mental Retardation Task Force on Emotional Disturbance is conducting a survey of facilities that provide residential services to emotionally disturbed youth. The results of this survey will help us prepare recommendations to the legislature to improve services for this population of students.

We would greatly appreciate your help in completing the enclosed survey, requesting information about services in your facility. Please send your completed survey to:

Dr. Kimberly Hoagwood
Texas Education Agency
Special Education Programs, Room 5-120
1701 N. Congress Avenue
Austin, Texas 78701-1494

Feel free to make other comments that you think would be helpful to us as we gather data on the appropriateness and cost-effectiveness of residential placements for students with serious emotional disturbance.

Please return completed surveys by February 28.

Thank you for your assistance with this project.

Description of Services

Please answer these questions for youth whom you are serving in the 1989-90 school year.

1. Youth from Texas served in your facility who are diagnosed by the schools as seriously emotionally disturbed.

   Age range ____________ Mean age ____________

2. Number of Males ____________ Number of Females ____________

3. Average length of stay ________ days

   ________ weeks

   ________ months

4. Number of youth who are:

   ________ Black Hispanic ________

   ________ White Other ________

5. Services provided: (check what children usually get as minimum services)

		Amount of time per week
Individual Counseling	____________	____________
Group Counseling	____________	____________
Family Counseling	____________	____________
Medication Management	____________	____________
Individual Behavior Modification Program	____________	____________
Group Modification Program (i.e., level system)	____________	____________

6. Therapeutic orientation of your facility staff (number of staff).

________ Dynamic	________ Systems
________ Behavioral	________ Family-centered
________ Cognitive	________ Humanistic
________ Other	

7. When youth were dismissed, what were the typical DSM diagnoses?

(OVER)

8. What were the usual diagnoses youth enter under?

9. In the past three years how many youth were dismissed and then returned to your facility?

10. Number of youth on the waiting list at any one time________________.

11. Average cost per day per youth ________________.

12. Any additional services families could anticipate upon discharge?

13. Costs of these services?

14. What recommendations do you typically make for follow-up treatment?

15. How many youth whom you have served over the last year are not in special education? (i.e., parent placement through insurance coverage) ____

16. What are the primary diagnoses of these youth?

____
Your name

____
Name of your facility

Residential Facility Survey Respondents as of September 1, 1990

N=44
Response Rate: 32 percent

- Baywood Hospital #70, Webster
- Brookhaven Youth Ranch, West
- Buckner Children's Services, Amarillo
- Charter Hospital of Corpus Christi, Inc., #76, Corpus Christi
- Charter Hospital of Dallas/Ft. Worth #119, Grapevine
- Coastal Bend Youth City, Inc., Driscoll
- Colonial Hills Hospital #81, San Antonio
- The Country Place, Dallas
- CPC Capital Hospital #94, Austin
- Dallas County MHMR Center, Dallas
- Darden Hill Ranch School, Driftwood
- DePelchin Children's Center, Houston
- Five Oaks Residential Treatment Center, Houston
- Greenleaf Center, Inc., #114, Killeen
- HCA Beaumont Neurological Hospital #14, Beaumont
  - HUG Children's Inpatient
  - Adolescent Program
  - Adolescent Substance Abuse Program
- HCA Cedar Crest RTC, Belton
- HCA Cedar Crest #109, Belton
- HCA Gulf Pines Hospital #80, Houston
- HCA Sun Valley Regional Hospital #36, El Paso
- High Sky Children's Ranch, Midland
- Hope Cottage-Girls Foundation, Dallas
- Juliette Fowler Homes, Inc., Dallas
- Junior Helping Hand Home, Austin
- Laurel Ridge, A Brown School, San Antonio
- Lena Pope Home, Inc., Ft. Worth
- Live Oak Hospital #73, Victoria
- Mary Lee Foundation, Buda Campus, Buda
- Nueces County MHMR Community Center/Adolescent Rehabilitation, Corpus Christi
- New Horizons Ranch, Goldthwaite
- Odyssey Harbour, Inc., Keene
- St. David's Pavillion #118, Austin
- St. Joseph Youth Center, Dallas
- St. Teresa's Home, Ft. Worth
- San Marcos Treatment Center #46, San Marcos
- Spring Shadows Glen #48, Houston
- Tarrant County Psychiatric Center, Fort Worth
- Tejas Home for Youth, Houston
- University Park Hospital #69, Tyler
- Willow Creek Adolescent Center, Arlington
- Woods Psychiatric Institute #53, Abilene
- Youth and Family Enrichment Center, Tyler

Appendix B: Residential Placement Outcome Survey Instrument

TEXAS EDUCATION AGENCY/TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION JOINT TASK FORCE ON EMOTIONAL DISTURBANCE

February 8, 1990

Dear Special Education Director:

The TEA/TDMHMR Joint Task Force on Emotional Disturbance has been given certain tasks by the 71st Legislature. One of these is to evaluate the use of residential placements for emotionally disturbed students. As a special education director who has placed a student/s in residential placement, your help can be very valuable to us.

We realize you are very busy, but if you could please take the time to complete the attached questionnaire for each student you have placed in residential placement during the last three years (including 1989/90), we would be most appreciative. Please make a copy of this questionnaire for each student you have placed residentially during this period.

Also, please feel free to contribute more information than the questionnaire asks for. If you would care to, for example, write a letter with your views of residential treatment, your ideas for alternatives to residential treatment, or any other aspect of this issue, we would be most appreciative.

If you would like to receive a copy of the results of this survey, please indicate this on the last page.

Please mail your replies to:

Dr. Kimberly Hoagwood
Texas Education Agency
1701 N. Congress Room 5-120
Austin, Texas 78701-1494

THANK YOU SO VERY MUCH.

Members of the Joint Task Force

PLEASE COMPLETE ONE OF THESE FORMS FOR EACH STUDENT IN RESIDENTIAL PLACEMENT DURING THE LAST THREE SCHOOL YEARS (including this one). Please make extra copies of this form, as needed. Thanks.

Appx. ADA of the district *_____Are you a member of a Special Education Coop?_____

Your regional service center #____

Pseudonymn for student:________________

Age when placed:_________Grade when placed:_________Sp.Ed. codes:______________

Facility the child was placed in:____

Major reason for placement, as stated in the application:

What non-educational factors influenced the child's residential placement?

Please list the services/costs you obtained from the residential placement:

Service:	Cost:

What services, programs, or other conditions, if present, would have prevented the placement of the student in residential?

Has the child progressed since being in the facility? Please be as frank as possible:

Has the child returned from the facility? Yes________ No ________

What were the criteria or reasons the child returned from the facility?

Do you anticipate the child will need to return to the facility or another one like it? Yes ________ No ________ If so, please explain the conditions that may lead to the return:

*Please use the district of the student placed

At the time you placed this child, did you have other children who had similar needs whom the district was able to serve without residential placement? Yes ________ No ________ If yes, please explain the rationale for the need for the differing placements:

How satisfied have you been with the facility chosen for this child:

- in ability to get the facility to follow the IEP?

- in real change in the condition of the child that caused the placement?

- in financial and other interactions with the facility?

- in your contacts with the facility staff members?

- in providing follow-up treatment after release?

What was the frequency of the district staff's visitation to the residential facility during the period of the child's placement?

Were residential staff members open to suggestions from the district?

Please use the following space to explain your feelings about residential placements as educational settings. (Please include any suggestions you have for alternatives to residential placement.)

Appendix C: Administrator Survey Instrument

ADMINISTRATORS SURVEY FOR ED TASK FORCE

To be completed by an administrator of single member district or cooperative special education program:

Region ESC ________ District/Cooperative ________________
Single Member District ________ or Cooperative ________

Approximate Number of Special Education Students Reported in December 1, 1989. Count ____________

Approximate Number of Special Education Students Reported in 1988-89 Superintendent's Report ________________

Approximate number of ED students whose parents reside in the district/cooperative and who are now in a residential placement (regardless of their entrance status, i.e., placed by parents, other agency, or school) ____________________

Number of ED students residentially placed by the school district or cooperative at the present time ______

Please describe the "community-based networks of outpatient services" which are currently available in your area for students who are emotionally disturbed who would otherwise be placed in a residential placement.

____
____
____

At this point, has your local district/cooperative entered into any interagency agreements with the area or county MH/MRA? __________ Please describe.

____
____
____

Currently, is there available in your community "a family-centered response and intervention system for students with emotional disabilities and their families?"

____

Comments:

____
____
____

(Optional and appreciated) Your recommendations for the ED Task Force:

____
____
____

Thank you again for your efforts in supporting services for students with emotional disturbance.

GCASE MID-WINTER CONFERENCE

FEBRUARY 1990

Dear Special Education Director:

Section 1.11 of SB No. 417 continues the joint task force on emotional disturbance composed of members of the Central Education Agency and Texas Department of Mental Health and Mental Retardation. The ED Task Force is now charged with conducting a study to evaluate and make recommendations concerning:

(1) the appropriateness and cost-effectiveness of residential placements of students with emotional disturbance;

(2) the creation of appropriate community-based networks of outpatient services for students who are emotionally disturbed who would otherwise be placed in a residential placement;

(3) the creation of a family-centered response and intervention system for students with emotional disabilities and their families; and

(4) early intervention and prevention strategies including early identification of students with emotional disabilities.

Your assistance is now requested in completed the survey on the back of this page and returning it immediately to the ED Task Force or mailing to the address below. Thank you for your assistance.

Best wishes,

Grace England

Grace England
ED Task Force Member

Return to:

Dr. Grace England
Klein Independent School District
7200 Spring Cypress Road
Klein, Texas 77379

Appendix D: Parent Survey Instruments

TEXAS EDUCATION AGENCY & TEXAS DEPARTMENT OF MENTAL HEALTH AND RETARDATION

1701 NORTH CONGRESS AVENUE
AUSTIN, TEXAS 78701
(512) 463-9414

JOINT TASK FORCE ON EMOTIONAL DISTURBANCE

The Joint TEA and TDMHMR Task Force on Emotional Disturbance will be making recommendations to the legislature regarding needed services for students with emotional disabilities, and their families. As interested parents, please take a few minutes to complete this questionnaire so that we can include your viewpoint in our recommendations.

1. Non-identifying child information (no names please):

Age ________ Grade ________ Sex ☐ Male ☐ Female

2 a. Your county: ______________________________

b. Is your child classified as seriously emotionally disturbed in school?

☐ Yes ☐ No

c. Have there been any additional diagnoses? If yes, what are they?

3 a. Is your child receiving special education services at school? ☐ Yes ☐ No

b. If yes, what is the instructional arrangement?

☐ resource
☐ partially self-contained
☐ self-contained
☐ separate campus
☐ other ______________________

4. When was your child first determined to have serious difficulties? ________ month/year

5. Who first made this determination? (Check more than one if applicable.)

☐ School Counselor
☐ Teacher
☐ Psychologist
☐ Psychiatrist
☐ Parents
☐ Private Physician
☐ Other School Staff ______________________________
☐ Other ______________________________

6a. What services do you receive or have you ever received ? (Check more than one, if applicable.)

b. Who provided these services? For example, school distrist, MHMR, DHS, private psychologist psychiatrist, or counselor; hospital outpatient program; community non-profit, etc.

☐ Individual Therapy ____________________
☐ Family Therapy ____________________
☐ Therapy for brother(s) or sister(s) ____________________
☐ Individual Support Group ____________________
☐ Parent Support Group ____________________
☐ Support Group for brother(s)/sister(s) ____________________
☐ Medication Management ____________________
☐ Respite Care (temporary supervision of child while family is away) ____________________

☐ Other ____________________ ____________________

BEST COPY AVAILABLE

7. Do you feel that adequate services are available in the community for families with needs such as yours?

☐ Yes, for child and family. ☐ Yes, for child only.
☐ No. ☐ To some degree.

8. What services would you like to see provided in the community? Please be specific.

Where would you like these services to be provided?

9. What other or more frequent community services do you feel your child and/or family needs? (Check as many as applicable.)

☐ Individual counseling ☐ Individual support groups
☐ Parent counseling ☐ Parent support groups
☐ Parent skills training ☐ Support group for brother(s)/sister(s)
☐ Family counseling (as a group) ☐ Respite/Temporary Relief Care
☐ Medication management
☐ Case Management, i.e. someone besides parent(s) to provide overall guidance and direction for decisions you are making about your child.

☐ Other ______________________________

10. Who would you say is now providing case management for your child, i.e. who is providing overall guidance and direction for the decisions you are making for your child?

☐ Parents only OR ☐ Parent(s) in combination with:
- ☐ School Special Education staff
- ☐ MHMR staff
- ☐ Private physician
- ☐ Private counselor, psychologist, psychiatrist
- ☐ Another family member or friend
- ☐ Other ______________________

11. Has your child ever been placed residentially? ☐ Yes ☐ No
If yes, please answer A through E below.

A. **How many facilities has your child been in ?** ______________

B. **Please check the most appropriate:**

☐ Child still in residential facility
☐ Child is back at home. We **were satisfied** with residential treatment and feel he/she **has improved**
☐ Child is back at home. We **were satisfied** with residential treatment but **do not feel he/she has improved**.
☐ Child is back at home. We were **not satisfied** with residential treatement.

Please comment:

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C. What was the major reason for residental placement as stated in the application to the facility?

D. What else do you personally feel might have influenced your child's placement in a residential facility, such as family, financial or other factors, or lack of appropriate services at school or in the community?

E. Please note the services you, your child or other family members obtained during the residential placement:

☐ Individual therapy
☐ Group therapy
☐ Family therapy
☐ Parent support group
☐ Medication management

☐ Other: ____

F. What follow-up services were provided, if any, after discharge? **(Check as many as applicable.)**

☐ Individual outpatient counseling: ☐ free ☐ additional charges
☐ Family outpatient counseling: ☐ free ☐ additional charges
☐ Day treatment
☐ Parent training
☐ Referrals to counseling sources within the community
☐ Individual support group
☐ Family support group
☐ Medication Management
☐ Personal follow-up by facility staff: ☐ by telephone ☐ visited home

☐ Other: ____

Thank you so much. Please feel free to make other comments below or on the back. Return completed survey by June 10 to Dr. Kimberly Hoagwood, Texas Education Agency, 1701 N. Congress, Room 5-120, Austin, Texas 78701-1494. If you have questions, please call Dr. Hoagwood at 512-463-9524.

TEXAS EDUCATION AGENCY & TEXAS DEPARTMENT OF MENTAL HEALTH AND RETARDATION

1701 NORTH CONGRESS AVENUE
AUSTIN, TEXAS 78701
(512) 463-9414

JOINT TASK FORCE ON EMOTIONAL DISTURBANCE

ESFUERZO COLABORATIVO PARA ESTUDIANTES CON PROBLEMAS EMOCIONALES

El esfuerzo colaborativo entre la Agencia de Educación de Texas (TEA) y el Departamento de Texas de Salud Mental y Retraso Mental (TDMHMR) encargado del área de problemas emocionales va a hacer recomendaciones a la legislatura relacionadas con los servicios para estudiantes con problemas emocionales y sus familiares. Si a usted como padre le concierne este tema, les rogamos se tome un momento para completar este cuentionario y así se incluya su punto de vista en nuestras recomendaciones.

1. Información sobre el estudiante (no escriba su nombre por favor)
   Edad ______ Año escolar _____ Sexo _____ masculino _____ femenino

2. a. Nombre de su condado ________________________________
   b. ¿Está su hijo(a) considerado(a) como estudiante con serios problemas emocionales? Marque sí o no.
      ___ Sí
      ___ No
   c. ¿Existen diagnósticos adicionales? ¿Cuáles son? Especifique.

3. a. ¿Está su hijo(a) utilizando algunos servicios que ofrece el programa de Educación Especial (Special Education) en su escuela?
      ___ Sí
      ___ No
   b. Si su respuesta es "sí", ¿cuál es el medio de instrucción que se le ha asignado?
      ___ Recurso - el estudiante utiliza el programa de Educación Especial (Special Education) parte del día.
      ___ Independiente - el estudiante pasa todas las horas escolares en este programa de Educación Especial.
      ___ Parcialmente independiente - entre recurso e independiente.
      ___ Escuela totalmente dedicada a programas de Educación Especial.
      ___ Otro tipo de arreglo educacional.

4. ¿Cuándo se determinó que su hijo(a) tenía problemas serios de tipo emocional? mes ____ año _____.

5. ¿Quién fue el primero en determinar la existencia del problema?
___ Consejero escolar
___ Maestro
___ Psicólogo
___ Psiquiatra
___ Padres
___ Médico
___ Otros miembros del personal de la escuela
___ Otro

6. a. ¿Cuáles de estos servicios utiliza o ha utilizado usted? Marque todas las respuestas que se apliquen en su caso.
___ Terapia individual
___ Terapia familiar
___ Terapia hermanos
___ Grupo de apoyo para el individuo
___ Grupo de apoyo para hermanos
___ Administración de medicamentos
___ Servicio de cuidado del hijo(a) (supervisión provisional mientras la familia se encuentra fuera)

b. ¿Quién proporciono estos servicios? Por ejemplo, el distrito escolar, el Departamento de Salud Mental y Retraso Mental (TDMHMR), el Departamento de Recursos Humanos (DHS), el psicólogo, el psiquiatra privado o consejero escolar, el programa para pacientes dados de alta, servicios comunitarios sin fines lucrativos.

7. ¿Siente usted que los servicios disponibles en su comunidad son adecuados para familias con necesidades como las suyas?
___ Sí, para el niño o la niña solamente.
___ Sí, para el niño o la niña y su familia.
___ No, los servicios no son adecuados. Especifique.

8. ¿Cuáles servicios le gustaria a usted que se proporcionaran en su comunidad? Por favor especifique lo más que pueda.

¿En dónde le gustaria a usted que estos servicios sean proporcionados? Por favor especifique lo más que pueda.

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9. ¿Qué otros tipos de servicios comunitarios considera usted que su hijo(a) y su familia necesitan con más frecuencia?
Por favor marque todos los que se apliquen a su caso.
___ Terapia individual
___ Terapia para padres de familia
___ Sesiones para ayudar a los padres con los problemas emocionales de su hijo(a)
___ Terapia familiar (como grupo)
___ Administración de medicamentos
___ Administración del caso; otra persona aparte de los padres que proporcione guía y dirección de las decisiones que se toman con respecto al tratamiento del estudiante
___ Grupo de apoyo para el individuo
___ Grupo de apoyo para los padres
___ Grupo de apoyo para hermanos
___ Servicio de custodia o ayuda de cuidado provisional
___ Otro ______________________________

10. ¿Quién está a cargo del caso de su hijo(a)? ¿Esto es, quién le proporciona la guía y dirección necesarias para tomar decisiones con respecto al tratamiento de su hijo(a).

___ Solamente los padres o
Los padres en combinación con:
 ___ Personal del programa de Educación Especial
 ___ Personal del Departamento de Salud Mental y Retraso Mental (TDMHMR)
 ___ Médico privado
 ___ Consejero escolar, psicólogo, psiquiatra privado
 ___ Otro pariente o amigo
 ___ Otro: ______________

11. ¿Ha estado su hijo(a) internado(a) previamente debido a problemas de tipo emocional?
___ Sí
___ No

Si la respuesta es "Sí", por favor conteste las siguientes preguntas.

A. ¿En cuántas instituciones como ésta ha internado a su hijo(a)? ______________.
B. Por favor marque la respuesta más apropriada:
 ___ Nuestro(a) hijo(a) todavía está internado(a) en una institución
 ___ Nuestro(a) hijo(a) ha regresado a casa. Estamos satisfechos con el tratamiento que recibió y sentimos que ha mejorado
 ___ Nuestro(a) hijo(a) ha regresado a casa. Estamos satisfechos con el tratamiento que recibió pero sentimos que no ha mejorado.
 ___ Nuestro(a) hijo(a) ha regresado a casa. No nos sentimos satisfechos con el tratamiento que ha recibido.

Por favor haga comentarios si lo considera necesario (puede usar el otro lado de la página para escribir sus comentarios).

C. ¿Cuál fue la razón principal por la que internaron a su hijo(a)? Por favor explique esta razón como lo ha hecho en la solicitud para utilizar los programas de Educación Especial?

D. ¿Qué otros motivos piensa usted que influyeron para que se haya internado a su hijo(a)? Incluya razones como familia, situación económica, falta de servicios apropriados en la escuela o en su comunidad u otros factores.

E. Por favor marque los servicios que usted, su hijo(a) u otros miembros de su familia han utilizado mientras estaba internado(a).

___ Terapia individual
___ Terapia de grupo
___ Terapia para la familia
___ Grupo de apoyo para los padres
___ Administración de medicamentos
___ Otro: ______________________________

F. ¿Qué servicios se le otorgaron a su hijo(a) al terminar su tratamiento?

___ Terapia individual para pacientes dados de alta
    ___ gratis ___ con cargos adicionales
___ Terapia para la familia de los pacientes dados de alta
    ___ gratis ___ con cargos adicionales
___ Tratamiento diurno
___ Sesiones para ayudar a los padres con los problemas emocionales de su hijo(a)
___ Servicios que recomienden otras fuentes de consejo psicológico en la comunidad.
___ Grupo de apoyo para el individuo
___ Grupo de apoyo familiar
___ Administración de medicamentos
___ Consultas privadas con el personal de la misma institución después de haber sido dados de alta.
    ___ por teléfono ___ visitó el hogar
___ Otro ______________________________

Le agradecemos su colaboración. Si usted siente que nos puede ayudar añadiendo otros comentarios, tómese la libertad de escribirlos atrás de esta página. Envíe el cuestionario a más tardar el 29 de junio de 1990 a Dr. Kimberly Hoagwood, Texas Education Agency, 1701 N. Congress Avenue, 3-101, Austin, Texas 78701-1494. Si desea hacer preguntas, favor de llamar a la Dra. Hoagwood al (512) 463-9524.

Appendix E: School Counselor Survey Instrument

We need
your help!

Jan. 10, 1990

Dear Director of Counseling/Head Counselor:

For the last several years, there has been a joint task force of the Texas Education Agency/Texas Mental Health and Mental Retardation studying the issues of emotional disturbance. This last year the Legislature appointed the Task Force to answer for them certain questions and propose certain recommendations, one of which relates to early intervention efforts to prevent emotional disturbance.

IT WOULD BE VERY HELPFUL TO US IF YOU COULD COMPLETE THE SHORT SURVEY FOLLOWING. As a member of that Task Force, I am researching this particular area of the question. I know you are very busy; but good recommendations depend upon the opinions of people "in the field."

Would you please supply the following information and mail to me as soon as possible. Just answer from your own perspective: there is no need to "look up" any other data. THANK YOU.

What is the approximate enrollment of your district?_________

What is your Regional Service Center number? #_________

If you have developed any certain kinds of services to deal with the emotional problems of your students within the regular education realm (example: student support teams, etc.), please list these below:

Any services at the elementary level (grades 1 through 5):

Any services at the middle school level (grades 6 through 8):

Any services at the high school level?

If you could have the services you would LIKE TO HAVE to prevent emotional disturbance, please list these services below by level:

Desired services at the elementary level:

Desired services at the middle school level:

Desired services at the high school level:

If you do have early intervention and prevention strategies (your answers on page 1), which of these services do you consider to be the most effective and why?

Within the realm of your special education department, what programs do you have to deal with emotional disturbance so that it hopefully does not get worse (i.e.,and perhaps end in residential treatment)?

Which of the strategies mentioned above for special education,if any, do you consider most effective and why?

Feel free to add any remarks or letters concerning the early prevention of emotional disturbance which you care to add. And THANK YOU so much!
(Return: Ruth Haak,Ph.D.,Dir.,Balcones Coop.601 Westbank Austin Tx78746)

Appendix F: The Comprehensive Community-Based Mental Health Service System for Children and Adolescents

Chapter 3. The Comprehensive Community-Based Mental Health Service System for Children and Adolescents

THE PURPOSES OF THE PLAN FOR CHILDREN AND ADOLESCENTS

Many of Texas' youth have multiple needs; rarely can a young person's problems be defined solely as mental illness or emotional disturbance. The department, therefore, is committed to developing joint programs and sharing resources with various other state departments and local agencies to address the complex problems of troubled youth.

Planning will focus on the creative use of all available resources, not just those under the control of the mental health system. Significant efforts will be expended to develop collaborative and cooperative relationships to focus on the individual needs of the child or adolescent rather than on the traditional or historic manner in which services have been delivered. This will allow children and adolescents who are in need of services from multiple agencies to receive the most appropriate and full range of services necessary.

Consistent with PL 99-660 and with applicable state law and policy, the following statements reflect the purposes of the plan for children and adolescents:

- To develop and present a vision of a comprehensive, community-based system of services for children and adolescents with serious mental illness.
- To provide for the effective administration and coordination of mental health services for children and adolescents at the state and local levels.
- To present strategies for directing current and potential resources to community-based services for children and adolescents.
- To fulfill the department's mission to provide a comprehensive service system for children and adolescents with serious mental illness in need of support, assistance, treatment, rehabilitation and advocacy.
- To coordinate with other child-serving entities to minimize duplication and to share with other child-serving entities in financing necessary services and programs.
- To incorporate an evaluation system to assist in determining the efficiency and effectiveness of the plan for children and adolescents with serious mental illness.

THE DEVELOPMENT OF THE PLAN FOR CHILDREN AND ADOLESCENTS

A planning process for children's services which is MHA-based and inclusive of local, regional, and state representatives of service providers, state agencies, and parents is crucial in the development, implementation, and monitoring of a service delivery system. The planning process described in Chapter 1 for the Texas strategic plan and this PL 99-660 plan has been inclusive of this chapter on services for children and adolescents.

Two additional groups have participated in the planning process for children's services. The Operation Planning Committee for Mental Health Services to Children and Adolescents, established in 1987, is responsible for the following: 1) to serve in an advisory role to the Deputy Commissioner for Mental Health Services; 2) to coordinate the planning of child and adolescent services for the system; 3) to assist in the implementation of PL 99-660 by providing support and technical assistance to the Planning Council and Regional Mental Health Councils; and 4) to assist in the coordination of regional and community interagency efforts.[64]

The Child and Adolescent Service System Program (CASSP) Advisory Committee, which is a subcommittee of the Children and Youth Services State Coordinating Committee (CYSSCC), will provide overall direction to the project tasks.[65] These groups were formed to enhance the development of adequate and appropriate mental health services for children and youth on a local, regional, and statewide level.

The number and composition of community-based services will be influenced by the demographic, ethnic, racial, and socioeconomic characteristics of each local service area. The community-based services of the local MHA provide the basis for all mental health services as a single-portal-of-entry for the priority population. Services shall include all core components, unless the local MHA, region, and state have determined that certain needs can best be met at the regional or state level. At the regional level, state hospitals or centers may be identified to provide certain services for the MHAs within the region, including but not limited to crisis stabilization units, specialized day treatment programs, and respite programs. Annual needs assessments will be conducted by each MHA regarding met, unmet, and undermet service needs of the priority population. It is the intent of the department that children and adolescents throughout the state will receive the benefits of appropriate and well-coordinated services.

As described in *Future Directions*, the department's six-year state strategic plan, the state hospitals will provide services for the most severely mentally ill and behaviorally disturbed youth. State facilities shall provide specialized programs which are not available in the region. In addition, state facilities shall provide specialty training for all levels of professional and paraprofessional mental health staff.

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[64] The roster of the Operation Planning Committee is in Appendix F.

[65] The roster of the CASSP Advisory Group is in Appendix G.

MISSION, PHILOSOPHY, AND PRINCIPLES OF SERVICES FOR CHILDREN AND ADOLESCENTS

The statutory mission of the department is stated in Chapter 1. The department will provide leadership to support the development of appropriate and sufficient community-based mental health services for children, adolescents, and their families. To be effective, a system of care for children and adolescents must encompass a holistic approach which has all of the following characteristics:

- an integrated system of child-serving agencies in a comprehensive continuum of services which respond to a child's physical, emotional, social and educational needs, and to include the education, juvenile justice, child welfare, health, and substance abuse agencies.

- a system sensitive to the effects of social, economic, cultural, and ethnic forces on child and youth development.

- a system which, at the state and community level, incorporates flexibility in funding, decision-making, service delivery, and structure to ensure responsiveness to children and adolescents as their needs change.

Children and adolescents are not merely small adults. Children differ from adults in their status as minors, in the mandatory involvement of the educational system, and in the essential ongoing involvement of a family, family surrogate, or conservator. A broad spectrum of laws impacts the provision of services to children, especially laws relating to abuse and neglect, custody, and right to consent. Children differ from adults, and younger children differ from older children, in their physical and emotional development.

The ways in which psychopathology manifests itself, and the technologies for effective intervention, are also different for children than for adults, and these differences become more dramatically evident the younger the age of the child. These same differences between children and adults have important ramifications for the development of effective services for this unique and very specialized population. The following service principles are the foundation for the development of services for children and adolescents.

EARLY IDENTIFICATION AND INTERVENTION. Early identification and intervention must occur in a manner which prevents inappropriate labeling of children or adolescents and enhances the likelihood of positive outcomes.

DEVELOPMENTALLY APPROPRIATE SERVICES. The tendencies and characteristics of each stage of development in the life of a young person are constantly changing, and must be correctly interpreted by staff who are knowledgeable in child development, cultural differences, and all levels of mental health services. The individual needs and potential of the child or adolescent, as well as the needs of the family, must dictate the types and mix of services to be provided, as guided by an individualized service plan.

MAINTAINING THE INTEGRITY OF THE FAMILY. If at all possible, the family should not be disrupted. The types of services available and the way in which services are provided should support the maintenance and enhancement of the family. It is important that the child or adolescent and the family, or surrogate family, participate in all aspects of the planning, delivery, and evaluation of services. Services shall not be denied to those children or adolescents whose families or significant others are unable or unwilling to participate in these activities. If a disruption of the family is unavoidable in the course of treatment, it should be as brief and non-damaging as possible. During the disruption, treatment should be provided as close to the youth's home community as possible and in the least restrictive environment appropriate.

MULTIPLICITY OF NEEDS. Rarely can a young person's problem be defined solely as mental illness or emotional disturbance. It is important to acknowledge that no one agency or service provider can adequately meet all of these needs. Rigid distinctions between mental health, mental retardation, and substance abuse problems are not helpful and impede the delivery of needed services. A genuine system of care must be developed among all agencies that provide services to children so that the services are integrated with structured and systemic linkages between the child-caring entities. Planning should focus on the creative use of all available resources, not just those under the control of the mental health system.

COMPREHENSIVE ARRAY OF SERVICES. In order for a treatment system to be effective, children, adolescents, and their families must have access to a comprehensive array of services which address the physical, emotional, social, and educational well-being of the child or adolescent and enhance family functioning.

COORDINATION OF SERVICES. In order for a treatment system to be effective, case management should be available to ensure that multiple services are delivered in a coordinated and therapeutic manner and that each child or adolescent has the ability to move into, through, and out of the system of services in accordance with his or her changing needs. Continuity-of-care and smooth transition to the adult service system should be available when necessary and appropriate.

PROTECTION AND ADVOCACY. The rights of children and adolescents must be protected and effective advocacy efforts for children and youth should be promoted. Services should be provided without regard to race, religion, national origin, sex, physical disability, or other characteristics, and be sensitive and responsive to cultural differences and special needs.

PROPOSED DEFINITION OF THE PRIORITY POPULATION FOR CHILDREN AND ADOLESCENTS

The department's current definition of its priority population (Chapter 2) is not appropriate for children and adolescents with serious mental illness. A proposed new summary definition of the priority population for children and adolescents with serious mental illness is *those individuals under 18 years of age who, because of psychosis or other emotional and/or behavioral disorders, suffer from severe disability which requires sustained treatment interventions for a year or more and which requires attention from two or more agencies.*

The diagnostic categories usually associated with serious and long-term mental illness or emotional disturbance in children and youth include pervasive developmental disorders; anxiety; and disruptive behavior disorders. These children are at risk of requiring long-term residential care and exhibit signs of deterioration in self-direction, judgement, learning, and the capacity for social relationships. The priority population definition for children and youth should also include children and adolescents who are at substantial risk of developing severe emotional disturbance.[66]

The Mental Health Community Standards and Definitions Work Group described in Chapter 4 will develop separate priority population definitions for children and adolescents as a part of their larger task. These new definitions are to be implemented in FY 1992.

NEEDS OF CHILDREN AND ADOLESCENTS IN THE PRIORITY POPULATION

There are 5,026,719 children from birth through age 17 residing in Texas. A nationally established prevalence rate for emotional disturbance among youth is 11.8 percent; therefore, 578,070 young Texans can be identified as emotionally disturbed and in need of mental health services. (See Figure 9). Of these, nearly half, or 251,336 children and youth, have been identified as seriously emotionally disturbed and are included in the department's priority population.

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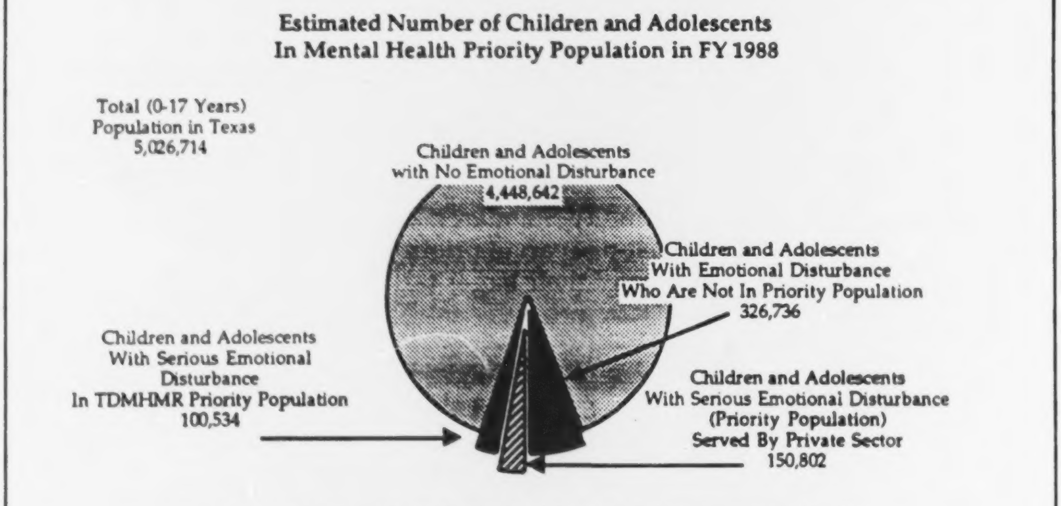
[66] NIMH. 1987. Toward a Model Plan for a Comprehensive, Community-Based Mental Health System. DHHS. pp. 37-38.

Of the estimated 251,340 children and adolescents with serious emotional disturbance in Texas, 150,800 were expected to receive services from the private sector in FY 1988. The number of children who were expected to require public mental health services (approximately 100,540) greatly exceeds the number of those who received those services (approximately 22,000 in FY 1989) (Table 2).

Figure 10 illustrates the number of children and adolescents in need of services by mental health region. Region 5, which includes Harris County (Houston), and Region 3, which includes the Rio Grande Valley, have the largest population of youth ages 0 through 17.

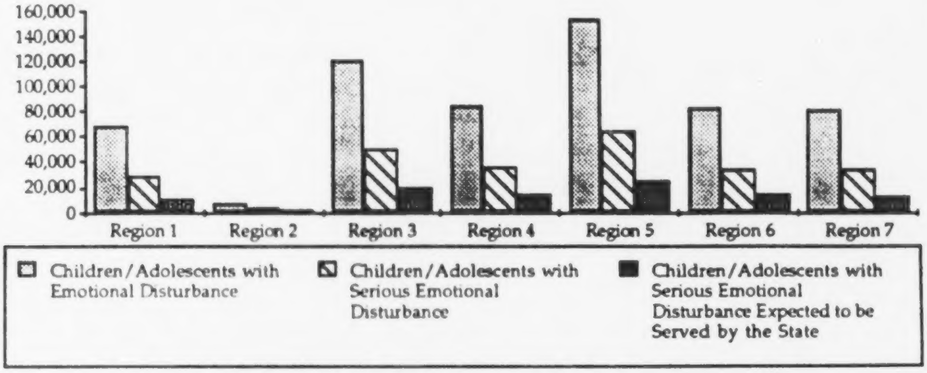
Children and adolescents who received public mental health services from community MHMR centers, state hospitals, and state centers in FY 1989 are listed by age and Service Group assignment in Table 2. The service groups listed are from the department's definition for FY 1987, which then included six service groups. As described in Chapter 2, the priority population definition now has five service groups.

Figure 9



(Data Based on State Mental Health Planning Guidelines, National Institute of Mental Health)

Figure 10



Estimated Number of Children and Adolescents in Need of Mental Health Services in FY 1988, by Mental Health Region

Source: From National Epidemiological Catchment Area Data, Holzer and Swanson, 1988.

Table 2 shows that adolescents who are 15 to 17 years old and in Service Groups I-IV were the highest users of state hospitals (inpatient and community programs) and community MHMR center services. The community MHMR centers provide services to the majority of children of all ages. Some differences are found both in age and in Service Group for those receiving treatment. Children ages birth through five years and in Service Group V, those ages 6 to 11 years in Service Group IV, and those ages 12 to 14 years in Service Group IV were the highest users of community MHMR center programs. Community MHMR center service utilization data also indicate that children and adolescents in the non-priority population group (MH VI) are receiving some level of services, even though there are no state mental health funds for those services.

Results from a recent TDMHMR study indicate that a large proportion of children and adolescents served by community MHMR centers receive treatment services whichare funded by local interagency contracts.[67] This is particularly true for those children and adolescents in priority population Service Group IV, and in the non-priority population Service Group V. More emphasis must be placed on providing treatment for those children and adolescents with mental illness who are at acute risk of becoming more disturbed and later requiring more costly and restrictive types of treatment.

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[67] The Child & Adolescent Resource Inventory, TDMHMR, September 1988.

Table 2. Children and Adolescents Receiving Mental Health Services From Community Centers And State Facilities By Age and Service Group, FY 1989

	Service Group	Age 0 to 5	Age 6 to 11	Age 12 to 14	Age 15 to 17	Row Total
Community Mental Health Centers	MH I	164	781	883	1,753	3,581
	MH II	62	235	316	636	1,249
	MH III	118	703	729	1,180	2,730
	MH IV	221	1,495	1,230	1,598	4,544
	MH V	309	702	470	625	2,106
	MH VI	32	245	185	244	706
	MR Group*	1,905	165	55	96	2,221
	Unclassified**	96	367	327	405	1,195
	Subtotal	**2,907**	**4,693**	**4,195**	**6,537**	**18,332**
Community Services, State Hospitals & State Centers	MH I	22	104	106	187	419
	MH II	0	9	13	31	53
	MH III	4	38	36	51	129
	MH IV	61	88	120	115	384
	MH V	13	122	114	134	383
	MH VI	1	17	13	10	41
	MR Group*	9	1	2	0	12
	Unclassified**	13	57	63	98	231
	Subtotal	**123**	**436**	**467**	**626**	**1,652**
Inpatient Services, State Hospitals & State Centers	MH I	1	110	306	883	1,300
	MH II	0	10	27	74	111
	MH III	0	5	30	61	96
	MH IV	1	12	38	79	130
	MH V	0	6	11	14	31
	MH VI	0	0	0	2	2
	MR Group*	0	8	3	10	21
	Unclassified**	0	13	54	136	203
	Subtotal	**2**	**164**	**469**	**1,259**	**1,894**
TOTALS		**3,032**	**5,293**	**5,131**	**8,422**	**21,878**

Note: Duplicated count; services may be received from more than one component.

*Persons receiving services at both state school and state hospital during year.

**Persons receiving services who were not classified into a service group.

Source: TDMHMR CARE system.

Table 3. Children and Adolescents Served in Community MHMR Centers By Age, Sex, and Ethnicity, FY 1989

	Age 0 to 5	Age 6 to 11	Age 12 to 14	Age 15 to 17	Row Total	Row Percent Of Subtotal
Male						
American Indian	2	5	0	7	14	0.13%
Asian	4	3	6	12	25	0.23%
Black	419	559	436	601	2,015	18.69%
Hispanic	362	561	493	828	2,244	20.81%
Other	12	12	9	5	38	0.35%
White	877	1,863	1,540	2,166	6,446	59.78%
Subtotal	**1,676**	**3,003**	**2,484**	**3,619**	**10,782**	**100.00%**
Female						
American Indian	2	1	2	10	15	0.20%
Asian	7	5	2	12	26	0.34%
Black	277	281	283	490	1,331	17.63%
Hispanic	283	327	388	587	1,585	20.99%
Other	4	7	8	2	21	0.28%
White	658	1,069	1,028	1,817	4,572	60.56%
Subtotal	**1,231**	**1,690**	**1,711**	**2,918**	**7,550**	**100.00%**
TOTALS	**2,907**	**4,693**	**4,195**	**6,537**	**18,332**	
Age % of Total	15.86%	25.60%	22.88%	35.66%	100.00%	

Source: TDMHMR CARE system.

Table 3 describes child and adolescent service utilization of community MHMR center services in FY 1989 by age, sex, and ethnicity. Of all male clients, white males ages 15 to 17 comprised the largest subgroup served. The largest numbers of Black, Hispanic, and Asian male clients served were also in the 15 to 17 age group. Of all female clients, the largest subgroup was white females and in the 15 to 17 age group. The largest number of minority female clients was in the 15 to 17 age group, as for males.

Table 4 illustrates FY 1989 utilization of state hospital and state center inpatient services by age, sex, and ethnicity. Both white males and females in age group 15 to 17 were the most frequent users of inpatient services. Of the ethnic minority populations, Black and Hispanic males and females in the 15 to 17 age group were the highest users of state inpatient services.

Table 4. Children And Adolescents Served By Campus-based State Hospital and State Center Services By Age, Sex, And Ethnicity, FY 1989

	Age 0 to 5	Age 6 to 11	Age 12 to 14	Age 15 to 17	Row Total	Row Percent Of Subtotal
Male						
American Indian	0	0	0	1	1	0.08%
Asian	0	0	0	3	3	0.24%
Black	0	17	31	77	125	9.97%
Hispanic	0	9	65	250	324	25.84%
Other	0	1	2	3	6	0.48%
White	1	98	178	518	795	63.40%
Subtotal	**1**	**125**	**276**	**852**	**1,254**	**100.00%**
Female						
American Indian	0	0	0	2	2	0.31%
Asian	0	0	0	0	0	0.00%
Black	1	6	28	46	81	12.66%
Hispanic	0	2	59	117	178	27.81%
Other	0	1	3	0	4	0.63%
White	0	30	103	242	375	58.59%
Subtotal	**1**	**39**	**193**	**407**	**640**	**100.00%**
TOTALS	2	164	469	1,259	1,894	
Age % of Total	0.11%	8.66%	24.76%	66.47%	100.00%	

Source: TDMHMR CARE system.

Table 5 compares the number of minority youth served in state hospitals with youth committed to the Texas Youth Commission (juvenile justice system) in 1988. These data show a higher proportion of minority youth among the TYC population than among the state hospital population. This raises several questions about the availability and acceptability of traditional mental health services to the Black and Hispanic communities. There may be a tendency for these youth to be viewed as "bad and mad" and more appropriate for juvenile justice intervention, instead of being "sad or emotionally disturbed" and in need of mental health intervention.

Figure 11 illustrates FY 1989 utilization by children and adolescents of state hospital and state center inpatient services and for all community-based services by mental health region. The lowest utilization of inpatient services was in Region 2 (Kerrville State Hospital, KSH). KSH does not provide inpatient youth services; children from this region in need of inpatient services go to San Antonio State Hospital, in Region 3.

Figure 11 also illustrates the number of youth between the ages of 0 and 17 served in community-based services by region in FY 1989. Region 5, which has the largest under-17 population, also has the highest utilization of community-based services. It must be noted that utilization of services is greatly affected by the availability and accessibility of services in the state and should not be viewed as an accurate representation of children who need services.

Table 5.

Adolescents in Juvenile Justice and Mental Health Systems

1988 Commitments	**Ages 12 to 14**	**Ages 15 to 17**
Texas Youth Commission		
Black	114	417
Hispanic	244	552
White	121	424
Other	0	17
Total	479	1,410
State Hospitals: Involuntary		
Black	23	52
Hispanic	50	156
White	108	316
Other	2	2
Total	183	526
State Hospitals: Voluntary		
Black	29	48
Hispanic	35	93
White	100	270
Other	5	2
Total	169	413

Sources: Texas Youth Commission, TDMHMR, FY 1988.

Several service system needs of the priority population were identified in 1984.[68] These needs included lack of coordination of services across agencies, lack of community-based services, and the need to develop funding initiatives specifically for children's programs. In addition, three special groups among the seriously emotionally disturbed priority population were identified whose service needs are especially critical. These groups are 1) violent or physically aggressive children; 2) children who are severely behaviorally disturbed, including substance abusers and fire setters, are sexually aggressive, and those with an I.Q. range of 50 to 70; and 3) children with severe mental illness requiring long-term treatment. More recent results identified the following additional service needs: 1) community-based residential alternatives; 2) crisis stabilization and emergency beds; 3) more staff who are professionally trained to work with children and youth; and 4) respite care.[69]

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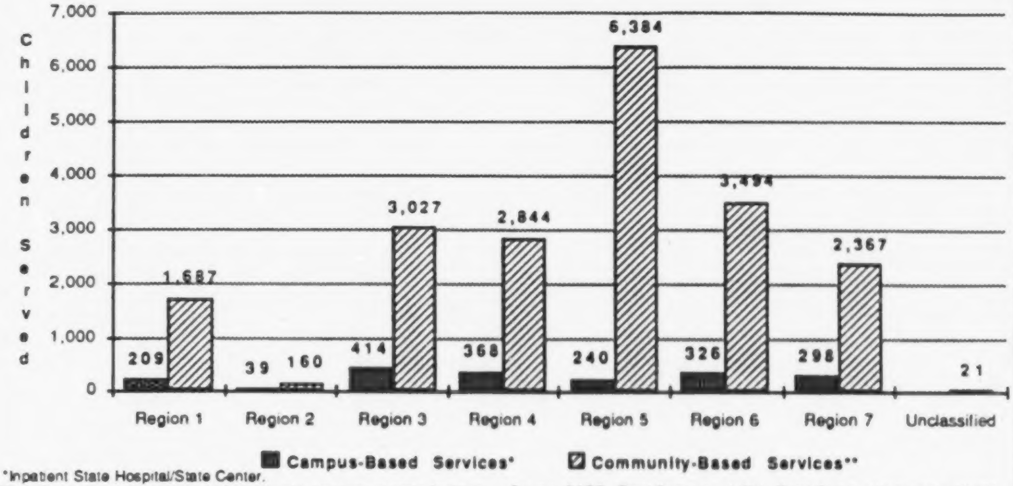
[68] Task Force on Mental Health Services for Children and Adolescents, TDMHMR, 1984.

Figure 11

Children and Adolescents Receiving Mental Health Services By Mental Health Region, FY 1989



*Inpatient State Hospital/State Center.
**Includes community centers and community services at state facilities. Source: CARE. Total Campus = 1,894. Total Community-based = 19,984

PROBLEMS IN THE CURRENT SERVICE SYSTEM

Low Priority of Services for Children and Adolescents

Children and adolescents comprise one-third of the total population in Texas. They are also a population that has traditionally been neglected or underserved by the state's human services system. The inadequacy of mental health services for children has long been an issue of concern in the country. As early as 1909, a White House conference on children identified the need for new programs to care for emotionally disturbed children.

The department, like other agencies, has historically been unable to meet the needs of all persons with serious mental illness. This has especially impacted services for children and adolescents. The mental health service delivery system has been plagued by the following problems: lack of a centralized focus within the department to coordinate the development of children's programs; lack of community-based services; lack of coordination between and among agencies serving children; and limited funding.

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[69] TDMHMR. 1988. Child & Adolescent Resource Survey.

The department's community-based services for children have been even more difficult to maintain, expand, or improve in recent years because of the recent system emphasis on services to adults with serious mental illness. Currently, the state is exploring the potential for Medicaid reimbursement for case management, day treatment, in-home, and evaluation services. In the Texas Department of Human Services (TDHS), expansion of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) programs is being proposed to help identify young children with mental health problems who are Medicaid-eligible.

Insufficient Community-Based Services

A monumental need for community-based services exists in Texas. Inadequate funding has resulted in insufficient services. The availability of community-based services, however limited, varies greatly by region. There is little or no correlation between the population size and the quantity of services provided. In general, the continuum of community-based services is more developed in the urban areas, reflecting local priorities. Only 9 of the 35 community MHMR centers in the state have an organized service program for children and adolescents. Region 5, which contains Houston, has the highest percentage of the state's population under 18 years of age. Second in rank is Region 6, which includes Dallas. The Dallas and Houston community MHMR centers are two of the nine centers that have separate and identifiable children and adolescent service units within their organization. Both community MHMR centers have been successful in developing interagency programs and in obtaining line-item local funding for children's mental health services. South Texas (Region 3) has the fastest growing population of children and youth under 18.[70] This region has the greatest need for inpatient and community-based screening, emergency, and residential services.[71] West Texas (Region 1) has 15 percent of the 0 through 17 years population; it has the lowest number of residential beds.

The delivery of mental health services to rural Texas is one of the system's greatest challenges. Those mental health regions with the largest rural populations are Regions 1 and 3. The capacity to develop services that will meet the needs of such a geographically and culturally diverse group of people is a complex task. Such a delivery system must be flexible enough in design to address the mental health needs of the predominantly Hispanic communities of the Rio Grande Valley and those isolated communities throughout West Texas. Rural communities in Texas are in a state of crisis because of plummeting oil and gas prices, declining land values, and the loss of the institution of family farming. A recent report on mental health in rural Texas indicates an increase in child abuse, substance abuse, and suicide among the youth population and their families.[72]

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[70] Task Force Report, 1984, op cit.

[71] TDMHMR, 1984. op. cit.

Inappropriate Priority Population Definition

Another major obstacle to development of a child and adolescent mental health delivery system is the department's priority population definition. The definition focuses on adults, with criteria of dangerousness and dependency and little emphasis on the level of social functioning. The current definition also does not reflect the multi-agency needs of many children and youth, who require interagency collaboration and coordination of services. The current definition has greatly limited the number of children who are eligible for department services.

Inadequate Identification of Children in Need of Services

Staff of public schools are often the first to recognize a child's deviant behavior or emotional problems. This recognition then initiates the process of referral and treatment. The prevalence rate for emotional disturbance for the school-age population in Texas is 0.66 percent.[73] One-third of the school districts in the state identify no students who are emotionally disturbed. Another one-third identify fewer than 0.05 percent. Of the roughly 21,000 students classified as emotionally disturbed, 44 percent have dropped out of school.[74] These statistics indicate that the majority of school districts are not in compliance with state and federal requirements that emotionally disturbed children be identified and receive appropriate services.

Since services to emotionally disturbed children are dependent on the identification process, they cannot be presumed to exist where identification is lacking. To solve this dilemma, a recommendation has been made that 2 percent of the total school population be accepted as the standard for prevalence of emotional disturbance in school-age children.[75] This complies with federal regulations under Public Law 94-142. Each school district would be monitored as part of ongoing compliance activities, and would have to document its attempts to screen the population that may be in need. Assistance must also be provided to the juvenile justice and child protective service systems in identifying and providing treatment for the seriously emotionally disturbed children under their jurisdiction.

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[72] Lois Barry, RN, MPH; Karen Mountain, RN, MSN; Mary Walker, RN, PhD, FAAN; Texas Office of Rural Health, Rural Mental Health in Texas: A Profile (1987)

[73] The Texas Education Agency, Texas Department of Mental Health and Mental Retardation Task Force on Emotional Disturbance (1988).

[74] Task Force, op. cit.

[75] Task Force, op. cit.

Lack of Interagency Coordination

The existing problems within and among the various child-serving agencies and the mental health system in providing services to children and adolescents with emotional disturbance is also indicative of the lack of coordination of services. Coordination of services is particularly crucial for those youth who are 18 to 22 years old and who must negotiate the transition from "children's" services to "adult" services. Coordination of resources across child-serving agencies is essential to the improvement of services for emotionally disturbed children and adolescents. The coordination effort must, of course, be led by the department.

Inadequate Inpatient Services

Five state hospitals and one community-based facility provide specialized inpatient care to children and adolescents in the priority population. Two additional facilities, the Waco Center for Youth and the Vernon Drug Dependent Youth Program, provide residential treatment to children and adolescents from around the state. The state inpatient services are designed for patients who are in need of acute psychiatric care. However, many children are forced to remain in the hospitals beyond the acute treatment phase because of limited residential placements and the lack of community-based services. In Texas, the number of residential beds for emotionally disturbed children is 3.2 per 100,000 population. The national average is 7.2 per 100,000. The more populous states, such as California, New York, and Pennsylvania, have 9 or more beds per 100,000 population.

SERVICES IN AN IDEAL, COMPREHENSIVE, COMMUNITY-BASED MENTAL HEALTH SYSTEM FOR CHILDREN AND ADOLESCENTS

Designing the System of Care

Central to the design and development of services to youth and their families is the philosophy of providing services within the least restrictive treatment alternative. The least restrictive treatment alternative for youth and their families is that which enables the individual to reach the highest potential for mental health. Youth and their families shall be provided treatment appropriate to their unique needs.

Treatment shall be provided in a setting which promotes the maximum interaction with the general peer population, and which is as close to the appropriate normalizing community and family environment as is feasible. However, consideration must be given to minimizing the potential detrimental effects on any individual as a result of the environmental alternative selected.

The design of the mental health service system to youth with serious mental and behavioral problems is a community-based system of care and treatment, with supportive levels of direct care at the regional and state level. The design incorporates the essential features of a continuum of services with specified alternative treatment environments, and is based upon the individual needs of the youth and his/her family or guardian. Design of the service system requires a joint working relationship among the department, the mental health regional councils, all mental health authorities, and families. The comprehensive service system for emotionally and behaviorally disturbed children and adolescents is a complex network of service systems, one of which is the mental health service system.

Mental health care and treatment for children and adolescents is comprised of three major components: non-residential services, case management, and residential services. In defining the specific components of the system of care and treatment, it is important to recall that these are components of an overall, interagency system. The services of the various agencies cannot operate in isolation created by artificial boundaries. Only when the services are integrated into a coherent, well-coordinated system will the needs of severely behaviorally/emotionally disturbed youth and their families be met in an appropriate and effective manner.

Implicit within any service system of care and treatment is the expectation that more youth require the less restrictive services than those who need the more restrictive, highly structured services. Therefore, the less restrictive services must have a greater service capacity than the more restrictive services. At all times, it is the intent of the service system to provide sufficient services of adequate quality in the less restrictive environment.

Non-Residential Services

Emergency Services focus specifically on crisis prevention, identification, and management. Crisis prevention is a system for ongoing community education and training of significant individuals and groups such as youth, parents, teachers, police officers, and juvenile detention workers to help them identify youth in crisis. The training assists these individuals and groups to respond to the youth in crisis and to use appropriate, available community resources.

The crisis hotline service is available 24 hours a day and may be used by youth or their families to gain access to immediate intervention services either over the phone or through a crisis intervention team. For emergency outpatient services, a crisis intervention team is available 24 hours a day for face-to-face crisis intervention. Team members are trained child and adolescent mental health workers. These services include not only emergency counseling, but also emergency evaluations. Such services operate closely with emergency residential components.

Early Intervention programs are for children who are at high risk for having or developing emotional problems. These children may have a history of abuse or neglect or a family history of mental illness or substance abuse. The large majority of these children are not being served through early intervention programs.

Assessment Services include professional determination of the nature of an individual or family's problems, the factors contributing to them, and the assets and resources of the individual and the family. On the basis of all this information, recommendations are made for treatment and related services. Assessments involve a wide range of tools and procedures, including physical health examinations, psychological tests, academic assessments, assessment of social and behavioral functioning, assessment of family functioning, and assessment of the youth's environment.

Outpatient Treatment serves youth with mild to moderate problems who can otherwise function in their natural environment. In some instances, this service may also be used for youth with moderate to severe problems in conjunction with other services with a more intensive nature, e.g., alternative family living and partial hospitalization. Services include the youth and/or family participation in individual, group, or family treatment. Parent training should also be provided, as well as case consultations to schools, courts, the Texas Department of Human Services, and other service providers.

Outpatient Family Support Services include family counseling, individual counseling for family members, information, parent support groups, and advocacy. All activities promote improved coping and problem-solving skills on the part of the family and child; strengthen constructive bonding within the family; and provide an opportunity for sharing of emotional support among families.

Home-Based Services are crisis-oriented and provide intensive services for youth and families in their own homes. Services are provided only to families who might otherwise have their youth placed out of the home and for recently reunited families. Services are crisis-oriented and provided to each family immediately after the referral. This service may also provide respite care to families.

Day Treatment/Psychosocial Rehabilitation Services serve youth with severe problems. Youth served in this component are often violent and assaultive, and who require an intensive staffing level to control and remediate their problems. Services are often provided in conjunction with residential treatment. Full educational/vocational services are generally provided within this setting. Other services provided include diagnosis and treatment planning, recreation, social skill development, group counseling, services to parents, and client advocacy. The services are generally provided four to eight hours a day, five days per week.

Components of the program typically include: 1) special education, generally in small classes, and with a strong emphasis on individualized instruction; 2) counseling, which may include individual and group approaches; 3) family services, including family counseling, parent training, brief individual counseling with parents, and assistance with specific tangible needs; 4) vocational training, particularly for adolescents; 5) crisis intervention, not only to assist youth through difficult situations, but also to help them to improve their problem-solving skills; 6) skill building, with an emphasis on interpersonal, problem-solving, and practical skills of everyday life; 7) behavior training, with focus on promoting success through the use of positive reinforcement procedures; and 8) recreational therapy, art therapy, and music therapy to further aid in the social and emotional development of the youth.

Medication-Related Services and medication clinics provide periodic review of psychiatric and behavioral status and an update on the maintenance or revision of prescriptive medication treatment by qualified physicians. Routine monitoring of the physiological status of the youth is done through laboratory tests and physical examinations, as appropriate for the prescriptive medications. Medication education is offered to the youth, if appropriate, or to the family, about the side-effects of the prescriptive medications, the importance of medication compliance, and about symptomatology which may suggest that a special medication review is indicated. Medications are provided for families whose personal resources do not allow for the purchase of prescribed medications; this service provides medication either directly, by paying for the medication, or indirectly through use of entitlements or other third party sources.

Case Management

Case management is "perhaps the most essential unifying factor in service delivery."[76] Activities include assessment of the youth's needs; planning for services to address those needs; linking and coordinating the flow of services to the youth; monitoring the services provided to the youth; and advocating for the youth. The case manager ensures that an adequate treatment plan is developed and is implemented, reviews progress with the youth, and aggressively provides outreach to the youth and his/her family.

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[76] Behar, 1985.

Residential Services

Residential programs provide living and sleeping arrangements for youth outside the youth's own home and often include such services as diagnosis, stabilization, extended treatment, and training services. The array of residential programs spans the continuum of restrictiveness from highly structured to semi-independent.

Structured Residential Programs

Crisis Stabilization Units provide a temporary, supervised residential environment to youth in crisis situations who need short-term residential alternatives and assistance until the crisis is stabilized or a long-term plan can be developed. A variety of crisis residential models should be available, although these models share common characteristics: 1) provide residential placement during crises; 2) are short-term; 3) provide acute and intensive treatment; 4) attempt to avert state facility hospitalization; and 5) are community-based. Crisis residential services may be provided through crisis shelters, therapeutic group homes, or crisis stabilization units.

Inpatient hospitalization uses a medical model to provide intensive treatment in a highly structured setting. Three basic functions of inpatient hospitalization are 1) short-term treatment and crisis stabilization in cases where a youth is in acute distress and possibly presenting a danger to himself/herself or others. In these cases, hospitalization may last for only a few days but more typically lasts for several weeks; 2) facilitate a comprehensive evaluation for youth who need special tests, particularly to identify neurological or biochemical aspects of their problems, and for youth who are unable or unwilling to cooperate with an outpatient evaluation. Such admissions are usually for a brief period up to approximately 30 days; and 3) long-term intensive treatment in a secure setting which may be necessary for severely disturbed and/or highly aggressive adolescents.

Intensive Residential Group Living offers highly structured and secure residential treatment to youth with severe emotional or behavioral disturbances. These youth are often highly aggressive, require a secure (generally locked) environment, and are usually too disturbed to attend public school or vocational training. Full services are generally provided within this setting. Emphasis is placed on containing and controlling the youth's violent and aggressive behavior. As soon as the youth's behavior is under programmatic control, he/she is moved to a less restrictive setting. Activities emphasize social skills development, emotional and cognitive development, and skills in daily living, vocation, and recreation. Liaison services are provided to the community and family.

Residential Group Living offers highly structured residential treatment to youth with moderate to severe problems, for whom removal from home is essential to facilitate treatment. Youth in this setting may use day treatment or have a job placement. Some may be able to attend public school; for others, special education services may need to be offered at times within the residential or day treatment program setting. These group homes provide healthy adult role models; group, individual, and family counseling as appropriate; liaison services to mobilize community and family resources; and social, emotional and cognitive training. Staffing is sufficient for an intensive level of supervision to control most aggressive behaviors. The facility may be locked if needed. The length of stay may be up to two and one-half years, according to a child's individual needs.

Intermediate Residential Programs

Alternative Family Living (specialized foster care) serves youth who are placed individually, or with other youth, in community foster care homes with specially trained and supported foster parents. Professional mental health workers provide back-up training, case management, and treatment services. These homes are sometimes referred to as therapeutic foster homes.

Residential Group Living (moderate supervision) offers residential treatment to youth with moderate to severe problems, for whom removal from home is essential to facilitate treatment. Youth in this setting will generally attend public school, but may use day treatment or have a job placement while in residence. These group homes provide healthy adult role models; group, individual, and family counseling as appropriate; liaison services to mobilize community and family resources; and social, emotional, and cognitive training. Staffing is sufficient for a moderate level of supervision. Length of stay will typically be six to eight months, but may be longer depending upon a child's individual needs.

Semi-Independent Residential Programs

Alternative Family Living (supervised independent living for transitional youth). Older adolescents (ages 16 through 18) may use this service component. Youth live with a highly trained alternative parent or supervisor in a home or apartment setting. Activities include parental care or supervision; emotional, physical, and cognitive development; social integration; prevocational skill building and/or work with the parents to reintegrate the youth into his/her own family, or work toward independent living.

Respite Care provides services for the families of youth who need periodic relief from the constant and often stressful care of the youth. Services may be provided either on a planned or emergency basis. While in respite care, the youth receives supervised care which meets the youth's basic health, nutritional, and daily living needs. Respite care has a variety of models, including community-based services which afford the opportunity for continuous care up to thirty days, contracted services with citizens using their own homes for respite care, or the availability of a companion sitter who can provide respite services in the home of the youth.

Standards for Quality Care

The quality of mental health services for children and adolescents in Texas shall not be less than for any other service group. Equivalent treatment services to youth does not mean identical services, and the provision of quality services generally requires higher levels of resources than those for adult clients.

Departmental facilities and community MHMR centers providing services to children and adolescents will adhere to the highest standards of care. The department will ensure that facilities maintain licensure and accreditation by a commitment of resources to monitor the quality of services and assist in compliance.

All facilities and program components will develop quality assurance plans which address issues and factors fundamental to effective, humane psychiatric treatment and related services. The department will make available staff with expertise in child and adolescent treatment to assist in developing and implementing these plans. Mechanisms for utilization review must be ongoing to ensure that the priority population is being served, and that access to and release from services occurs in accordance with standards set by the department and accrediting bodies. The department will monitor utilization rates and trends and will adjust the disbursement of resources accordingly. In all cases, standards for care and the ways in which they are monitored must be unique to the population being served and their specific treatment needs.

Program evaluation and outcome assessment information must be exchanged between central management and field programs in ways that contribute meaningfully to change. Program outcome assessment must include a mechanism for consumer and advocacy group input, such as exit interviews and follow-up studies.

GOALS AND OBJECTIVES FOR FY 1989, FY 1990, and FY 1991

Goal 1. Establish separate Service Group definitions for children and youth in the priority population.

The absence of appropriate Service Groups for children and youth has limited the number of children receiving service and the types of services they receive.

Objective 1.1. In 1990, develop priority population and service group definitions in conjunction with current revisions of mental health definitions and community standards.

Objective 1.2. In 1990, augment the Client Assignment and Registration System (CARE) to ensure the tracking of children and youth in the newly defined service groups by identifying interagency involvement and clinical characteristics of children currently in the MHMR system.

Objective 1.3. In 1991, incorporate approved service groups into the CARE system.

Goal 2. Develop mechanisms for community and regional planning that will ensure the development of appropriate mental health services to children and youth.

Mental health services to youth have been provided in varying levels of consistency across Texas; therefore, it will be necessary for each community and region to identify the system of services which exists in its area and the gaps in the current delivery system.

Objective 2.1. In 1989, establish CASSP program unit under the direction of the Coordinator of Children and Youth Services.

Objective 2.2. In 1990, through the CASSP program unit, establish regional interagency advisory committees to assist in service expansion efforts.

Objective 2.3. In 1990, establish children and youth subcommittees in each MHA to ensure that planning which occurs in the community is integrated with state level planning.

Objective 2.4. In 1990, through the CASSP Advisory Committee (a subcommittee of the Children and Youth Services State Coordinating Committee) establish linkages with advocacy groups, parents, and community and regional child-serving agencies to be involved in planning efforts.

Objective 2.5. In 1990, through the CASSP program, complete a multi-agency needs assessment and key informant study to identify youth in need of mental health services and the types and amounts of services in the community that will meet the need.

Objective 2.6. In 1990, through the CASSP program, identify the mental health services for children and youth which are available in the community.

Objective 2.7. In 1991, develop and implement a methodology for determining the level of need for inpatient beds.

Objective 2.8. In 1991, develop a projected time frame for implementation of needed services.

Goal 3. Develop a community-based system of care for children and youth.

To appropriately and adequately serve children and youth, a broad array of comprehensive mental health services, referred to in this plan as a "system of care," must be provided. Mental health services must be seen as part of a much larger system, which involves many other service providers. Mental health specialists must be prepared to assist youth with mental health needs, regardless of the system with which they initially come in contact. The ability to coordinate services, share funding, and permit funding to follow the child or youth must be enhanced and become the normal procedure at both state and local levels.

The full system of services as listed in this plan will require well-developed linkages among the various service components within the mental health system and between the mental health and the other child-serving systems. There must also be flexibility in funding and in decision making to allow the movement of youth from one service to another as needs dictate. Staff must be trained specifically to work with children and youth to ensure appropriate services.

Objective 3.1. In 1990, define and solicit requests for proposals for children's services in urban, mixed urban/rural, and rural areas for the $2 million appropriated for the FY 1990-1991 biennium.

Objective 3.2 In 1990, utilize the CASSP Advisory Committee to guide implementation of program goals and objectives.

Objective 3.3. In 1990 and 1991, through the CASSP program unit, provide training and technical assistance to community MHMR centers, facilities, and other child-serving agencies on the identification of and provision of services to severely emotionally disturbed youth.

Objective 3.4 In 1990, develop a directory of mental health services in Texas for children and youth and disseminate to all MHAs to facilitate networking and referrals among service providers.

Objective 3.5 In 1990, disseminate available information regarding state-of-the-art programs and services, as well as current research, on issues of concern for children and youth to public and private providers of mental health services.

Objective 3.6. In 1990, identify specific core services to be developed at the community level in FY 1992-93.

Objective 3.7. In 1992, begin implementation of core services which include: crisis stabilization; case management; screening and referral; client and family support; medication-related services; 24-hour emergency hotline; multidisciplinary assessment within 24 hours of initial crisis; psychosocial rehabilitation; and community-based residential services.

Objective 3.8. In 1993, develop service delivery strategies which target the following special populations: violent and aggressive children and youth; children and youth requiring long-term residential care; children and youth with 50 to 70 IQ with serious emotional disturbance; minority children and youth; rural children and youth; severely emotionally disturbed youth who are substance abusers; and youth who are transitioning to adulthood.

Goal 4. Improve interagency coordination and cooperation among the other state, local, and private agencies that provide social services to children, adolescents, and their families.

Most of Texas' youth in need of services have multiple problems. Rarely is the need for services related only to emotional or behavioral problems. It is far more common for a young person to need mental health services and also special education, a temporary substitute home, and/or health care to overcome basic physical problems. Historically, state and local agencies have designed their programs around specific "problems," so that what a youth received depended more upon which agency accepted him or her as a client than upon the actual needs of the child or adolescent. The narrow, categorical channels through which services could be accessed and funded actually kept a multi-need youth from receiving the services that were appropriate to meet his/her needs.

While this is a national problem, it is accentuated in states like Texas, where services to children and youth are delivered through a number of state and local agencies. To address this issue, the 70th Legislature enacted Senate Bill 298, which mandates the coordination of services to "multi-problem children and youth." This mandate includes the establishment of the Children and Youth State Coordinating Committee and development of local community resource groups which will conduct interagency staffings.

Objective 4.1. In 1990 and 1991, develop memoranda of understanding with other child-serving agencies to enhance the expansion of service system development.

Objective 4.2. In 1991, with the Children and Youth Services State Coordinating Committee, establish local service coordination groups to support and coordinate service development efforts.

Objective 4.3. In 1991, enhance training and technical assistance to interagency collaboration efforts, to help improve overall effectiveness in addressing the service needs of severely emotionally disturbed and mentally ill children and youth, especially minorities.

Goal 5. Identify budget allocations and funding incentives for the development of mental health services for children and youth.

Current funding in Texas is not adequate for a comprehensive mental health system of services for children and youth. The department and the local MHAs will work to seek additional funding for services to children and adolescents. Interagency funding of services will also be emphasized.

Objective 5.1. In 1990, identify, by MHA, the funds being used for mental health services specific to children and adolescents.

Objective 5.2. In 1990 and 1991, identify potential local, state, federal and private resources available for mental health services for children and adolescents.

Objective 5.3. In 1990, estimate the costs of providing the services not currently available, and develop a projected timeline as to when the services currently not available can be funded.

Objective 5.4. In 1990, identify funding strategies which will assure the provision of core services in FY 1992-1993.

Objective 5.5. In 1990, develop appropriations request to fund and implement core services during FY 1992-1993.

Objective 5.6. In 1990, support and assist in the implementation of Medicaid mental health service expansion.

Objective 5.7. In 1991, support statewide efforts to expand insurance coverage for services not currently covered sufficiently (e.g., case management, residential).

COMPLIANCE STATEMENT

TITLE VI, CIVIL RIGHTS ACT OF 1964; THE MODIFIED COURT ORDER, CIVIL ACTION 5281, FEDERAL DISTRICT COURT, EASTERN DISTRICT OF TEXAS, TYLER DIVISION

Reviews of local education agencies pertaining to compliance with Title VI Civil Rights Act of 1964 and with specific requirements of the Modified Court Order, Civil Action No. 5281, Federal District Court, Eastern District of Texas, Tyler Division are conducted periodically by staff representatives of the Texas Education Agency. These reviews cover at least the following policies and practices:

(1) acceptance policies on student transfers from other school districts;

(2) operation of school bus routes or runs on a non-segregated basis;

(3) nondiscrimination in extracurricular activities and the use of school facilities;

(4) nondiscriminatory practices in the hiring, assigning, promoting, paying, demoting, reassigning, or dismissing of faculty and staff members who work with children;

(5) enrollment and assignment of students without discrimination on the basis of race, color, or national origin;

(6) nondiscriminatory practices relating to the use of a student's first language; and

(7) evidence of published procedures for hearing complaints and grievances.

In addition to conducting reviews, the Texas Education Agency staff representatives check complaints of discrimination made by a citizen or citizens residing in a school district where it is alleged discriminatory practices have occurred or are occurring.

Where a violation of Title VI of the Civil Rights Act is found, the findings are reported to the Office for Civil Rights, U.S. Department of Education.

If there is a direct violation of the Court Order in Civil Action No. 5281 that cannot be cleared through negotiation, the sanctions required by the Court Order are applied.

TITLE VII, CIVIL RIGHTS ACT OF 1964; EXECUTIVE ORDERS 11246 AND 11375; TITLE IX, 1973 EDUCATION AMENDMENTS; REHABILITATION ACT OF 1973 AS AMENDED; 1974 AMENDMENTS TO THE WAGE-HOUR LAW EXPANDING THE AGE DISCRIMINATION IN EMPLOYMENT ACT OF 1967; AND VIETNAM ERA VETERANS READJUSTMENT ASSISTANCE ACT OF 1972 AS AMENDED IN 1974.

It is the policy of the Texas Education Agency to comply fully with the nondiscrimination provisions of all federal and state laws and regulations by assuring that no person shall be excluded from consideration for recruitment, selection, appointment, training, promotion, retention, or any other personnel action, or be denied any benefits or participation in any programs or activities which it operates on the grounds of race, religion, color, national origin, sex, handicap, age, or veteran status (except where age, sex, or handicap constitute a bona fide occupational qualification necessary to proper and efficient administration). The Texas Education Agency makes positive efforts to employ and advance in employment all protected groups.